

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH.**

Registered No. 8501

BIRTH NO. 50

1. NAME OF DECEASED  
(Type or Print)

*Andrew Harris (Anworth)*

DATE  
OF  
DEATH

*Oct. 2, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*Med. Csl 2*

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*JOHNS HOPKINS HOSPITAL*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*620 N. Central Ave*

5. SEX

*Male Colored*

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

*Single*

8. DATE OF BIRTH

*1-3-19*

9. AGE (in years last birthday)

*31*

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Unknown*

10B. KIND OF BUSINESS OR INDUSTRY

*Gen. Work*

11. BIRTHPLACE (State or foreign country)

*North Carolina*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Levy Harris*

14. MOTHER'S MAIDEN NAME

*Mamie*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no or unknown)

*No*

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

*JOHNS HOPKINS HOSPITAL*

ADDRESS

*✓*

18. *026X*

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Cerebral thrombosis*

DUE TO

*48 hrs.*

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Meningo-vascular syphilis*

DUE TO

*?*

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

*Syphilitic aortitis with aortic insufficiency*

*?*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *9-30-*, 19*50*, to *10-2-*, 19*50*, that I last saw the deceased alive on *10-2-*, 19*50* and that death occurred at *4 P.* m., from the causes and on the date stated above.

23A. SIGNATURE

*Victor A. McKusick*

23B. ADDRESS

*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED

*X-3-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*10-7-50*

24C. NAME OF CEMETERY OR CREMATORY

*5010*

24D. LOCATION (City, town, or county)

*Weldon N. C.*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

*Elroy Wilson 1100 Broadway*

ADDRESS

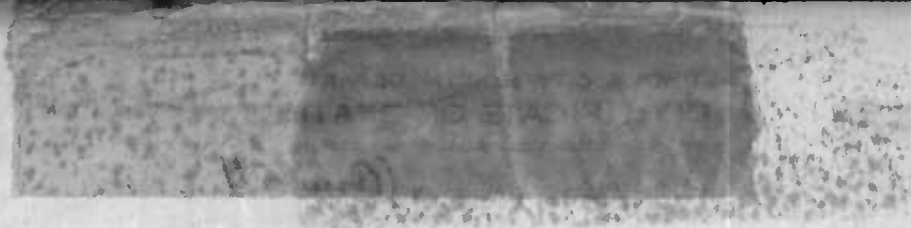
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*OCT-4-1950*

*97099*

*0300*

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**Lee Sommer**

2. DATE  
OF  
DEATH

**Oct. 2, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland **Baltimore, Md.**

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

**Esplanade Apts. Eutaw Place.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Md.** B. COUNTY **Esplanade Apts. Eutaw Place.**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore, Md.**

D. STREET ADDRESS (If rural, give location)

**Eutaw Place, Balto. 17, Md.**

5. SEX

**Male**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

**Married**

8. DATE OF BIRTH

**Mar. 21, 1875**

9. AGE (In years  
last birthday)

**75**

10. Under 1 Year  
Months: Days: Hours: Min.

**6 11**

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

**Private business**

10B. KIND OF BUSINESS OR  
INDUSTRY

**Jewelry business**

11. BIRTHPLACE (State or foreign country)

**Germany**

12. CITIZEN OF  
WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**Isaac Sommer**

14. MOTHER'S MAIDEN NAME

**Sak Sarah ?????**

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, unknown) (If yes, give war or dates of service)

**No**

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

**Mrs. Erlanger 3311 Strathmore Ave.**

18. **420.0**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

**Coronary Occlusion -**

INTERVAL BETWEEN  
ONSET AND DEATH

**1 hr.**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

**Coronary Thrombosis -**

**1 hr.**

DUE TO

(C)

**Arteriosclerotic Heart Disease -**

**2 yrs.**

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

**Auricular Fibrillation -**

**9 mo.**

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **March 10, 1950** to **Oct. 2, 1950** that I last saw the deceased alive on **Oct. 2, 1950** and that death occurred at **9:25 A.M.** from the causes and on the date stated above.

23A. SIGNATURE

**H. Wm. Primackoff**

23B. ADDRESS

**Emersonian Apts.**

23C. DATE SIGNED

**Oct. 3, 1950**

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

**Burial**

24B. DATE

**Oct 5, 1950**

24C. NAME OF CEMETERY OR CREMATORY

**Oheb Shalom Cemetery**

24D. LOCATION (City, town, or county)

**Baltimore, Md.**

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**OCT-4 1950**

**David M. Shalom & Son**

**David M. Shalom & Son**

**1902 Eutaw Pl**

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OFFICE OF THE ATTORNEY GENERAL

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**CAROLINE WILHELMINA HARRISON**

2. DATE  
OF  
DEATH

**Oct. 3, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

**Maryland**

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

**Baltimore**

D. STREET ADDRESS (If rural, give location)

**321 Woodlawn Road**

B. FULL NAME OF HOSPITAL OR INSTITUTION

**321 Woodlawn Road**

Length of stay in Baltimore

**life**

Yrs.  
Mos.  
Days

5. SEX

**F**

6. COLOR OR RACE

**W**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Married**

8. DATE OF BIRTH

**June 25, 1877**

9. AGE (in years last birthday)

**73**

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Housewife**

10B. KIND OF BUSINESS OR INDUSTRY

**at home**

11. BIRTHPLACE (State or foreign country)

**Baltimore, Md.**

12. CITIZEN OF WHAT COUNTRY?

**USA**

13. FATHER'S NAME

**Frank Hoegl**

14. MOTHER'S MAIDEN NAME

**Marie Schmidt**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or not known) (If yes, give war or dates of service)

**no**

16. SOCIAL SECURITY NO.

**none**

17. INFORMANT ADDRESS  
**Mr. George W. Harrison  
321 Woodlawn Road**

18. **332X**

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Cerebral Thrombosis**

DUE TO

**3 weeks**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **arteriosclerosis**

DUE TO

**?**

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **September 18, 1950**, to **October 3, 1950**, that I last saw the deceased alive on **October 2, 1950**, and that death occurred at **1 A. m.**, from the causes and on the date stated above.

23A. SIGNATURE

**Francis W. Gluck**

23B. ADDRESS

**3406 St Paul St**

23C. DATE SIGNED

**10/4/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**burial**

24B. DATE

**10/5/50**

24C. NAME OF CEMETERY OR CREMATORY

**LOUDON PARK CEMETERY**

24D. LOCATION (City, town, or county)

**Baltimore, Md.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Hunter for Williams, Md**

25. FUNERAL DIRECTOR

**HENRY SANDER & SONS, INC. BALTO., 13, MD.**

ADDRESS

**Henry F. Sander**

**OCT-4 1950**

VS 150

**0834**

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2022 07

2022 07



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*LOUISE CHASE*

2. DATE  
OF  
DEATH

*10-4-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore-Md.*

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

*FRANKLIN SQUARE HOSP.*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*Baltimore-Md.*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*CHESAPEAKE BEACH-Md.*

5. SEX

*FF.*

6. COLOR OR RACE

*C.*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*SINGLE*

8. DATE OF BIRTH

*6-14-1925*

9. AGE (In years  
last birthday)

*25*

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

*Cook*

10B. KIND OF BUSINESS OR  
INDUSTRY

*REST.*

11. BIRTHPLACE (State or foreign country)

*Md.*

12. CITIZEN OF  
WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*THOMAS CHASE*

14. MOTHER'S MAIDEN NAME

*LETHA THOMAS*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

*Edna Chase Chesapeake Beach Md.*

18. *587.0*

**CAUSE OF DEATH**

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) *Acute Hemorrhagic Pancreatitis* 5 days

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

*Oct. 3, 1950*

19B. MAJOR FINDINGS OF OPERATION

*Acute Hemorrhagic Pancreatitis*

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *10/1*, 19*50*, to *10/3*, 19*50*, that I last saw the  
deceased alive on *10/3*, 19*50*, and that death occurred at *2 P* m., from the causes and on the date stated above.

23A. SIGNATURE

*Benjamin Amsterdam*

M. D.

23B. ADDRESS

*Franklin Square Hospital*

23C. DATE SIGNED

*10/4/50.*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

*Burial*

*10/7/50*

*St Edmonds*

*Calvert Co Md*

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Oct-5-1950*

*William Williams*

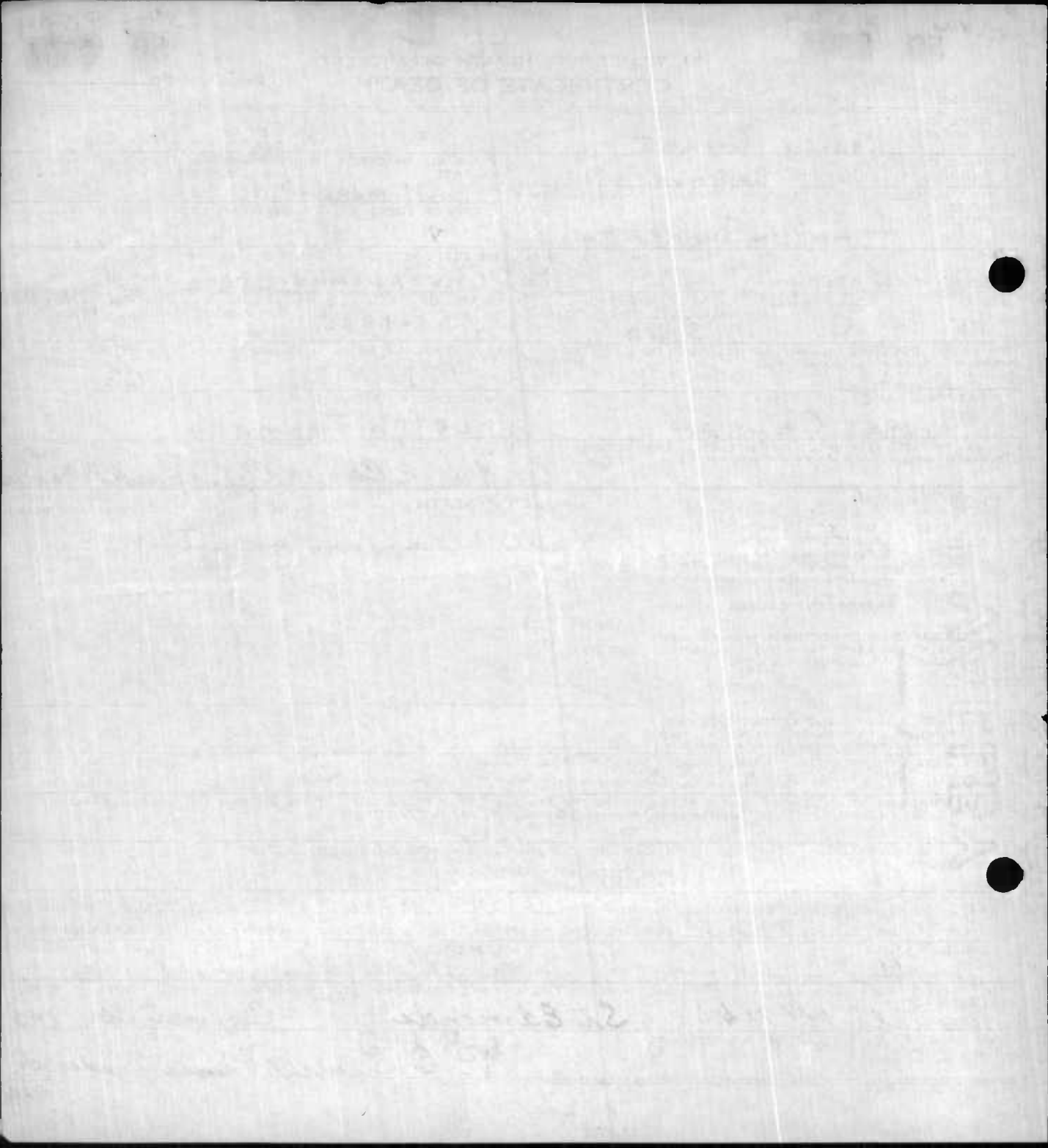
*P. E. Sewell Pinner Frederick Md*

VS 150

*754 6 M*

*1280*

correct age is especially important. Physicians: please write the causes of death clearly and legibly.





300

50 8505

Susie BEATTIE

50 8505

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Susie Beattie (Mrs. Simon)

2. DATE  
OF  
DEATH

October 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hospital

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

Maryland

B. COUNTY

Harford

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Whiteford, Md

D. STREET ADDRESS (If rural, give location)

None

6200

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

January 19, 1884

9. AGE (In years  
last birthday)

66

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Whiteford, Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Hughes

14. MOTHER'S MAIDEN NAME

Julia Morrison

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Kenneth Beattie Balair, Md.

18. E903.0 I

CAUSE OF DEATH

acute pulmonary edema due to

(A) Hypertensive Cardiovascular Disease

INTERVAL BETWEEN  
ONSET AND DEATH

6 days

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Fracture Neck left Femur

1 week

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

10-2-50 - well leg fracture

Fractured neck l. femur.

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Whiteford

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

Sept. 2 28 1950 4 P.m.

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☒  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

Patient fell on porch of home having  
a fractured neck of l. femur22. I hereby certify that I attended the deceased from September 29 1950, to October 5, 1950, that I last saw the  
deceased alive on Oct. 5, 1950, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Charles H. Watt, Jr., M.D.

23B. ADDRESS

Union Memorial Hosp.

23C. DATE SIGNED

10/5/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT-5-1950

REGISTERED FOR

Funeral Director

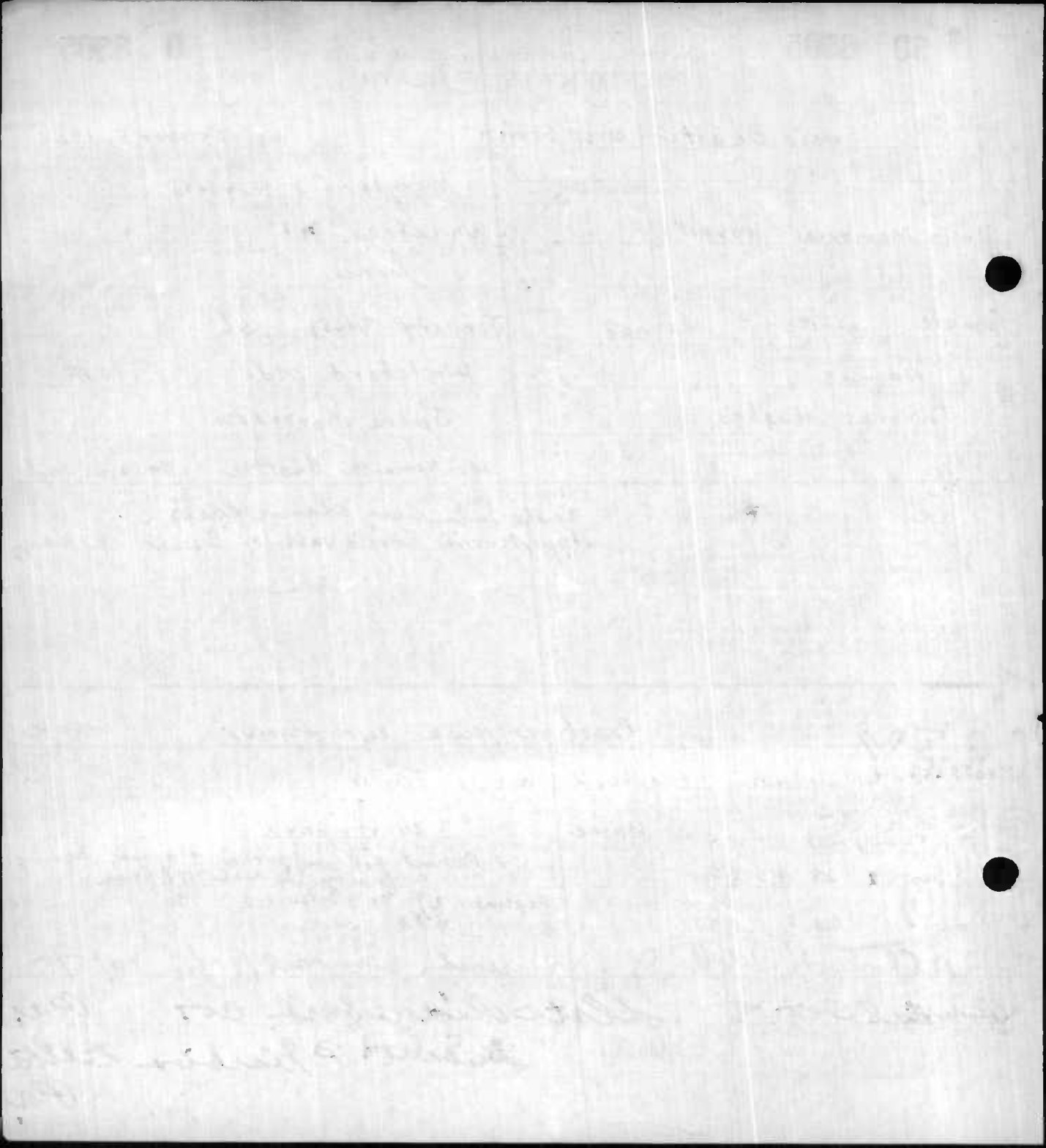
ADDRESS

VS 150

N820.0

186a Pa.

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No.

BIRTH NO.

50-19232

1. NAME OF DECEASED  
(Type or Print)

Baby Boy Garrison (Wayne)

2. DATE  
OF  
DEATH

Oct. 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore Md

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR Luthan Hospital at Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 16-06

D. STREET ADDRESS (If rural, give location)  
2724 Fr. Mosher St.

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Sept 9, 1950

9. AGE (In years last birthday)

0 Months 25 Days

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Walter J. Garrison

14. MOTHER'S MAIDEN NAME

Josephine C. Scardina

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

Walter J. Garrison 2724 Fr. Mosher St

18. 561.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A)

gangrenous appendicitis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

incarcerated hernia ing.

DUE TO

II

(C)

primaturity

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

same

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Sept. 9, 1950 to Oct. 4, 1950 that I last saw the deceased alive on Oct. 4, 1950, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Arundel

23B. ADDRESS

Luth Hosp. at Maryland

23C. DATE SIGNED

Oct. 5, 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct 5, 1950

24C. NAME OF CEMETERY OR CREMATORY

Meadowridge

24D. LOCATION (City, town, or county)

Anne Arundel Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

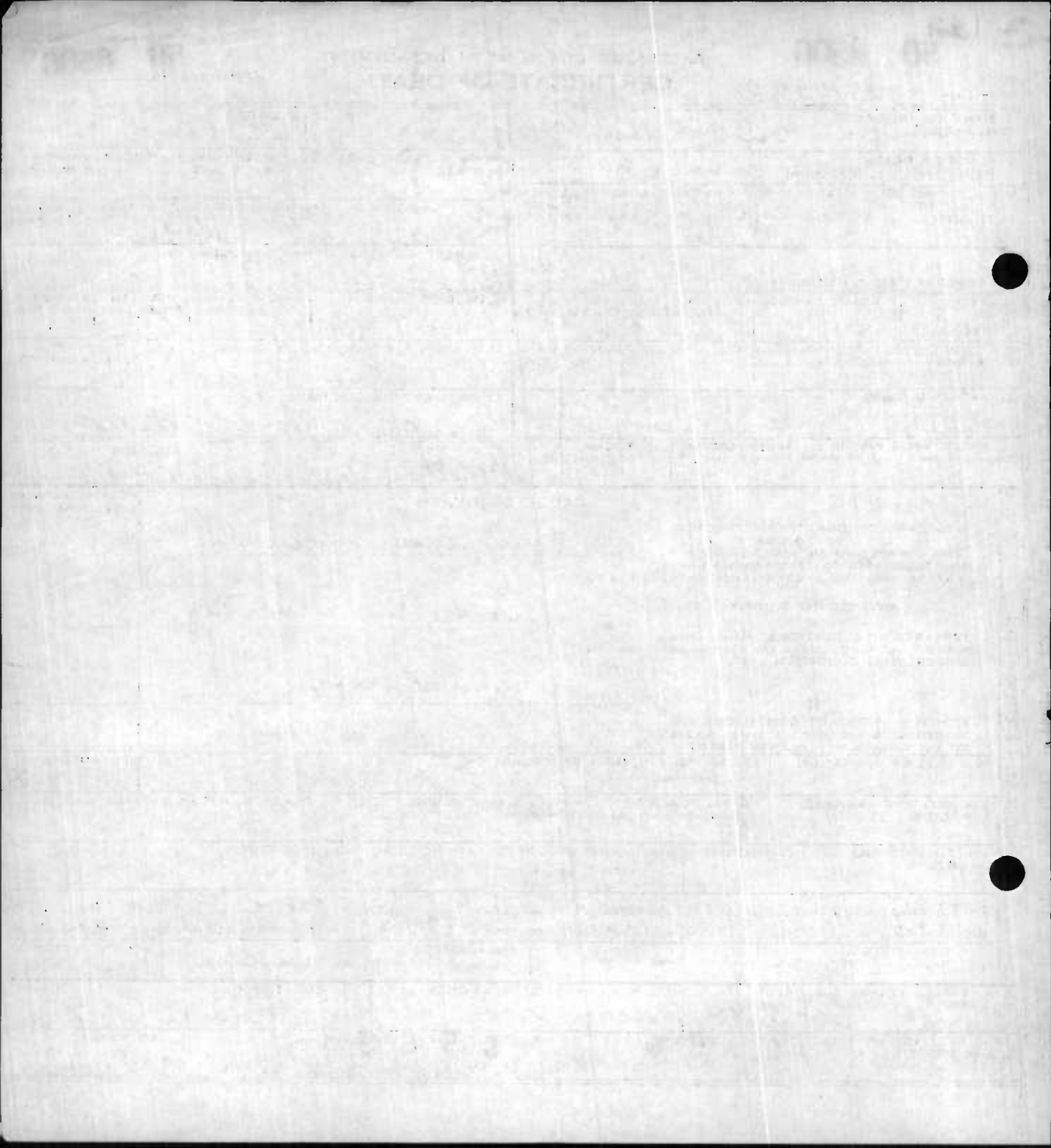
ADDRESS

061-51550

John H. Williams, Jr.

John H. Williams, Jr.

5311 Edmondson Ave.



correct age is especially important. Physicians: please write the causes of death clearly and legibly.

324 50 8507

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8507

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Harriett Ann Mitchell</u>		2. DATE OF DEATH <u>Oct. 3, 1950</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>	
Length of stay in Baltimore <u>1 yr.</u>		D. STREET ADDRESS (If rural, give location) <u>1303 Eden St.</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married (Sep)</u>	8. DATE OF BIRTH <u>1-6-1894</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) <u>56</u>
13. FATHER'S NAME <u>James ?</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>N. Carolina</u>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <u>Harriett Dunston</u>	
17. INFORMANT <u>Jesse Mitchell</u>		ADDRESS <u>Vaughan, N.C.</u>	
18. <u>422.1</u> <u>162 X</u> CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <u>Cerebral Thrombosis</u> DUE TO			<u>4 days</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <u>Arterio-sclerotic cerebral vascular disease</u> DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Pneumonia - left lower lobe</u> (C)			<u>3 days</u>
19A. DATE OF OPERATION <u>Sept. 27, 1950</u>		19B. MAJOR FINDINGS OF OPERATION <u>Secondary carcinoma of lung (rm)</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept. 23, 1950</u> , to <u>Oct. 3, 1950</u> that I last saw the deceased alive on <u>Oct. 3, 1950</u> , and that death occurred at <u>6:20 p.m.</u> , from the causes and on the date stated above.			
23A. SIGNATURE <u>J. Joseph Kucin</u>		23B. ADDRESS M. D. <u>1400 N. Caroline St.</u>	
23C. DATE SIGNED <u>Oct. 3, 1950</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24B. DATE <u>10/5/50</u>	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State) <u>Vaughan, N.C.</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>OCT - 5 1950</u>	REGISTRAR'S SIGNATURE <u>Arthur J. Williams, Jr.</u>	25. FUNERAL DIRECTOR <u>Joseph S. Lick. Jr.</u>	ADDRESS <u>1304 N. Central Ave</u>

possible  
Was this a primary site of malignancy  
indicated in clinical history?  
"yes - lung"

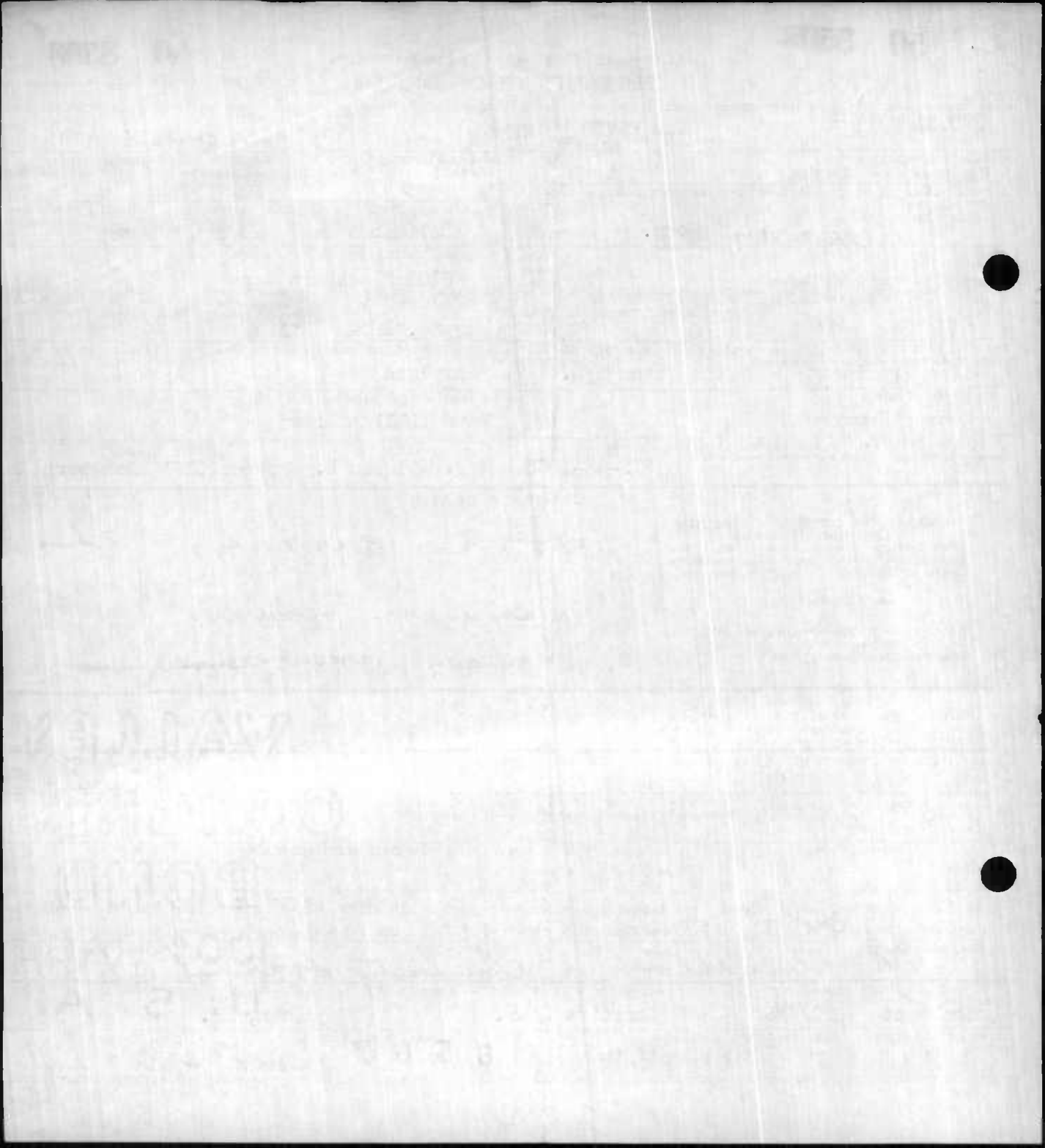
See Document File 50-8507

10-18-50

ES







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>W. Stewart Anderson</i>		2. DATE OF DEATH <i>Oct. 4, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 27-12</i>	
Length of stay in Baltimore _____ Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>200 St. Dunstan's Road Baltimore</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>March 12, 1891</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance Broker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>	9. AGE (In years last birthday) <i>59</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>J. Fred Anderson</i>		14. MOTHER'S MAIDEN NAME <i>Laura Herring</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Wife - same address as deceased</i>		ADDRESS _____	

18. <i>245X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH (A) <i>Leukemia due to lower nephron nephrosis</i> DUE TO _____  ANTECEDENT CAUSES (B) <i>Drug sensitivity</i> DUE TO _____  (C) _____  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH  <i>8</i>  <i>14</i>
---	---

19A. DATE OF OPERATION <i>none</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>Sept 22</i> , 19 <i>50</i> , to <i>Oct 4</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Oct 4</i> , 19 <i>50</i> , and that death occurred at <i>8:19 a.m.</i> , from the causes and on the date stated above.				
23A. SIGNATURE <i>Lawler F. White</i>	M. D.	23B. ADDRESS <i>Mercy Hospital</i>	23C. DATE SIGNED <i>Oct 4, 1950</i>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>10/4/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT-5-1950</i>	REGISTRAR'S SIGNATURE <i>Wm. J. Dickner</i>	25. FUNERAL DIRECTOR <i>Wm. J. Dickner</i>	ADDRESS <i>Wm. J. Dickner &amp; Sons - Balto Md.</i>

Please state what drug  
was administered and whether there is  
any record of  
what was the condition  
that necessitated the drug?

See Document File 50-8509

10-18-50

EW

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 8510

BIRTH NO. 124

1. NAME OF DECEASED  
(Type or Print)

MARION De Von DePASCAL

2. DATE OF DEATH Oct. 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
Lutheran Hosp. of Md.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE Md.  
B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 16-07

D. STREET ADDRESS (If rural, give location)

1016 Rosedale St.

Length of stay in Baltimore  
Yrs. 0  
Mos. 0  
Days 0

5. SEX male  
6. COLOR OR RACE white  
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH Apr. 24, 1900  
9. AGE (In years last birthday) 50  
If Under 1 Year: Months 0 Days 0  
If Under 24 Hours: Hours 0 Min. 0

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Claim Investigator

10B. KIND OF BUSINESS OR INDUSTRY  
Railroad

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

George W. De Von De Pascal

14. MOTHER'S MAIDEN NAME

Catherine P. Wunder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
no

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS St.  
Mrs. Madeline E. De Pascal-1016 Rosedale

18. 443X

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pontine Hemorrhage

28 hrs.

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio-Vascular Disease?

DUE TO

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-3, 1950, to 10-4, 1950, that I last saw the deceased alive on 10-4, 1950, and that death occurred at 1:10 A.M., from the causes and on the date stated above.

23. SIGNATURE

Stanley R. B. Bael

23B. ADDRESS

Lutheran Hosp

23C. DATE SIGNED

10-9-50

24A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

24B. DATE

10/7/50

24C. NAME OF CEMETERY OR CREMATORY

Meadow Ridge

24D. LOCATION (City, town, or county) (State)

Howard Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

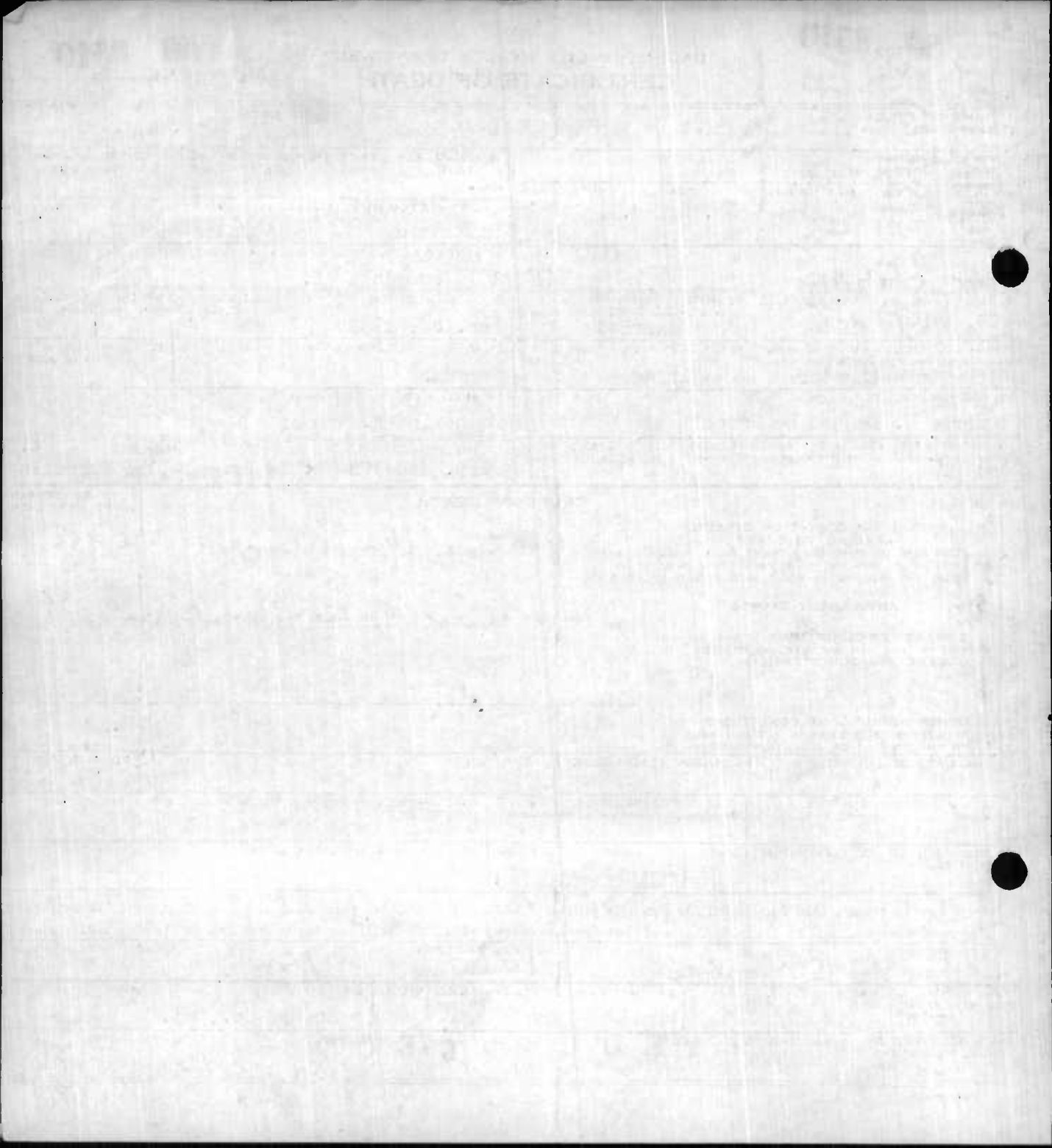
25. FUNERAL DIRECTOR

ADDRESS

OCT-5-1950

William H. Williams, Jr.

Wm. J. Pickner & Sons, Balto.





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**Simon S. Etzel**

2. DATE  
OF  
DEATH

**10-4-50**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

**Balto**

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

**114 North Port Street**

C. Length of stay in Baltimore

**life**

Yrs.  
Mos.  
Days

5. SEX

**M**

6. COLOR OR RACE

**W**

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

**Widowed**

8. DATE OF BIRTH

**8-19-70**

9. AGE (In years  
last birthday)

**80**

If Under 1 Year  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

**Retired Laborer**

10B. KIND OF BUSINESS OR  
INDUSTRY

**Amer. Sugar Refnry.**

11. BIRTHPLACE (State or foreign country)

**Baltimore**

12. CITIZEN OF  
WHAT COUNTRY?

**USA**

13. FATHER'S NAME

**Unknown**

14. MOTHER'S MAIDEN NAME

**Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

**no**

**no**

16. SOCIAL  
SECURITY NO.

17. INFORMANT

**Leonard S. Etzel**

ADDRESS

**114 N. Port Street**

18. **443X**

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

**cerebro vascular accident**

**72 hr.**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

**hypertensive CVD**

(C)

**hyp stat pneumonia**

**24 hr.**

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office hldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK AT WORK

22. I hereby certify that I attended the deceased from **Sept 30, 1950**, to **Oct 4, 1950**, that I last saw the  
deceased alive on **Oct 4, 1950** and that death occurred at **10 A. m.**, from the causes and on the date stated above.

23A. SIGNATURE

**Burton V. Lock MD**

M. D.

23B. ADDRESS

**2936 E. Balto St**

23C. DATE SIGNED

**10/5/50**

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

**Burial**

24B. DATE

**10-7-50**

24C. NAME OF CEMETERY OR CREMATORY

**Holy Redeemer**

24D. LOCATION (City, town, or county) (State)

**Baltimore**

**Md.**

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**Oct 5 1950**

**Walter J. Milian**

**Walter J. Milian**

**403 S. Wolfe Street**

10-1-50

John S. Ford

Mr.

Barry

111 North First Street

Barry, W.

111 N. First Street

111 N

111 N. First Street

111 N

111 N

111 N. First Street

111 N. First Street

111 N. First Street

111 N. First Street

111 N. First Street

111 N. First Street

111 N. First Street

111 N. First Street

Barry

10-1-50

John S. Ford

Barry

Mr.

111 N. First Street

*Handwritten signature*

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

460  
LC  
142239

50 8512

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8512

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Josiah Naylor</b>		2. DATE OF DEATH <b>October 5, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>Parkton, Maryland</b> <b>5300</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>March 22, 1943</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	
13. FATHER'S NAME <b>Josiah Naylor</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
12. CITIZEN OF WHAT COUNTRY? <b>✓</b>		17. INFORMANT ADDRESS <b>Baltimore City Hospitals</b> <b>Records- 4940 Eastern Avenue</b>	

18. <b>080.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Poliomyelitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
DUE TO (A)		
DUE TO (B)		
DUE TO (C)		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>10-5-50</b>		19B. MAJOR FINDINGS OF OPERATION <b>Poliomyelitis, Bulbar, Acute</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>10-4</b> , 1950, to <b>10-5</b> , 1950 that I last saw the deceased alive on <b>10-5</b> , 1950, and that death occurred at <b>1:20 Am</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>[Signature]</b>		23B. ADDRESS <b>4940 Eastern Avenue</b>		23C. DATE SIGNED <b>10-5-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>October 7, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Heverford Baptist</b>	
24D. LOCATION (City, town, or county) (State) <b>Parkton, Md. R.D.</b>		25. FUNERAL DIRECTOR <b>Jacob Hartman</b>		ADDRESS <b>New Freedom, Perma.</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>[Signature]</b>			

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

OFFICE OF THE COMMISSIONER  
ALBANY, N. Y.

IN SENATE  
JANUARY 1, 1910

REPORT  
OF THE COMMISSIONER

OF THE DEPARTMENT OF HEALTH  
FOR THE YEAR 1909

ALBANY: J. B. LIPPINCOTT & CO.,  
PRINTERS, 1910.

THE STATE OF NEW YORK  
DEPARTMENT OF HEALTH

OFFICE OF THE COMMISSIONER  
ALBANY, N. Y.

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ALBANY: J. B. LIPPINCOTT & CO.,  
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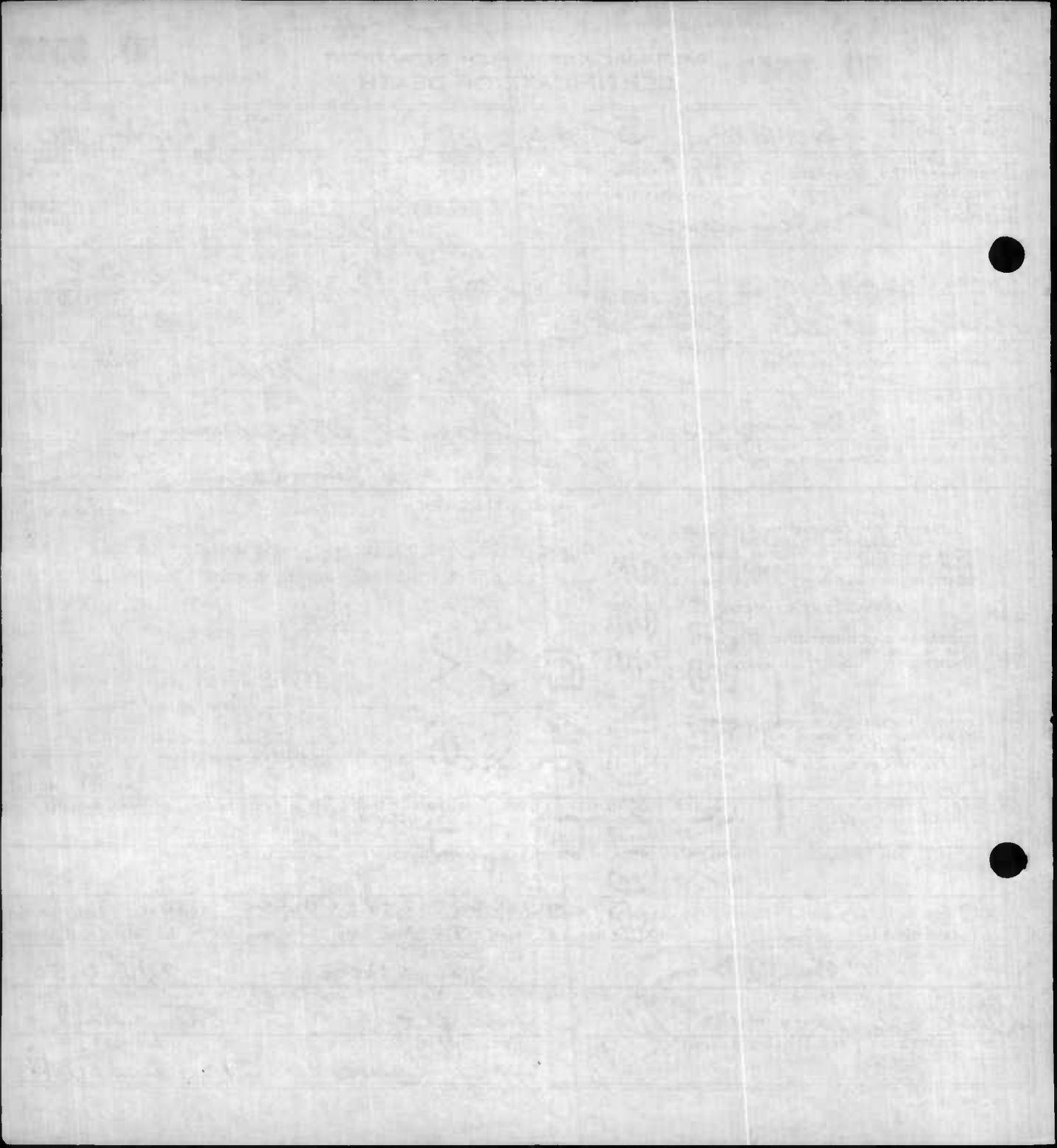
correct age is especially important. If physicians, please write the causes of death clearly and legibly.

subject to approval of medical examiner  
526 50 8513  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH  
Registered No. \_\_\_\_\_

BIRTH NO. 50-15473

1. NAME OF DECEASED (Type or Print) <b>SINGER, STANLEY</b>		2. DATE OF DEATH <b>4 October 50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>5423 Crum, ave</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>md</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Singer</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 28-31</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>5423 Crum Ave</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>7-23-50</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <b>5</b> If Under 1 Year: Months _____ Days _____ If Under 24 Hours: Hours _____ Min. _____	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto md</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Morris Singer</b>	
14. MOTHER'S MAIDEN NAME <b>Bernice Freeman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Morris Singer - Same</b>	
18. <b>7544</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Myocardial insufficiency due to congenital heart disease - endocardial fibro elastosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b>		(B) _____ (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CERTIFICATION APPROVED BY <b>B. B. Fisher</b>	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <b>4 Oct</b> , 19 <b>50</b> , to <b>4 Oct</b> , 19 <b>50</b> , that I last saw the deceased alive on _____, 19____, and that death occurred at <b>7:00A</b> m., from the causes and on the date stated above.	
23A. SIGNATURE <b>William V. Brown, Jr.</b>		23B. ADDRESS <b>Sinai Hosp.</b>	
23C. DATE SIGNED <b>8 Oct 50</b>		24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Funeral</b>	
24B. DATE <b>10-5-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto md</b>		25. FUNERAL DIRECTOR ADDRESS <b>Jack Lewis Inc 2100 Eutaw Pl</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT-5-1950</b>		REGISTRAR'S SIGNATURE <b>William V. Brown, Jr.</b>	

VS 150  
157E





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>CARRIE J. KOONTZ GANON</b>			2. DATE OF DEATH <b>October 4, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Lutheran Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
C. Length of stay in Baltimore <b>Life</b> Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>601 Ashburton Street</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Sept. 27, 1917</b>	9. AGE (in years last birthday) <b>33</b>	10. Under 1 Year Months: _____ Days: _____ 11. Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mesusse</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Swedish Massage</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Harry F. Koontz</b>			14. MOTHER'S MAIDEN NAME <b>Edith G. White</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>yes</b> (If yes, give war or dates of service) <b>World War II</b>			16. SOCIAL SECURITY NO. <b>215-18-9136</b>		
17. INFORMANT <b>Mrs. Mary M. Bragg</b>			ADDRESS <b>601 Ashburton Street</b>		

18. <b>E970.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>Barbiturate intoxication</b> (A) _____ DUE TO _____  ANTECEDENT CAUSES  (B) _____ DUE TO _____  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____ DUE TO _____  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH
--	----------------------------------

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>601 Ashburton Street</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>October 1, 1950 10.15 p.m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Ingestion of phenobarbital tablets</b>	
22. I certify that I took charge of the remains described above, held an <u>Inquiry &amp; Inspection</u> thereon and from <u>Autopsy, Inspection or Inquiry</u> the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>William V. [Signature]</i>		23B. CHIEF MEDICAL EXAMINER _____ M.D. ASSISTANT MEDICAL EXAMINER _____ MEDICAL INVESTIGATOR _____		23C. DATE SIGNED <b>Oct. 4, 1950</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24B. DATE <b>Oct. 7, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Anne Arundel County, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT-5-1950</b>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR <b>A. Howard Evans</b>	ADDRESS <b>1400 S. Charles St.</b>

V S 151      N-971-0      0978F      A. Howard Evans (Balto. 30, Ind.)

correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>	
<p>4. Place of birth: _____</p>	
<p>5. Date of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of physician: _____</p>	
<p>8. Signature of registrar: _____</p>	
<p>9. Signature of informant: _____</p>	
<p>10. Signature of witness: _____</p>	
<p>11. Signature of funeral home: _____</p>	
<p>12. Signature of coroner: _____</p>	
<p>13. Signature of medical examiner: _____</p>	
<p>14. Signature of health officer: _____</p>	
<p>15. Signature of registrar: _____</p>	
<p>16. Signature of informant: _____</p>	
<p>17. Signature of witness: _____</p>	
<p>18. Signature of funeral home: _____</p>	
<p>19. Signature of coroner: _____</p>	
<p>20. Signature of medical examiner: _____</p>	
<p>21. Signature of health officer: _____</p>	
<p>22. Signature of registrar: _____</p>	
<p>23. Signature of informant: _____</p>	
<p>24. Signature of witness: _____</p>	
<p>25. Signature of funeral home: _____</p>	
<p>26. Signature of coroner: _____</p>	
<p>27. Signature of medical examiner: _____</p>	
<p>28. Signature of health officer: _____</p>	
<p>29. Signature of registrar: _____</p>	
<p>30. Signature of informant: _____</p>	
<p>31. Signature of witness: _____</p>	
<p>32. Signature of funeral home: _____</p>	
<p>33. Signature of coroner: _____</p>	
<p>34. Signature of medical examiner: _____</p>	
<p>35. Signature of health officer: _____</p>	
<p>36. Signature of registrar: _____</p>	
<p>37. Signature of informant: _____</p>	
<p>38. Signature of witness: _____</p>	
<p>39. Signature of funeral home: _____</p>	
<p>40. Signature of coroner: _____</p>	
<p>41. Signature of medical examiner: _____</p>	
<p>42. Signature of health officer: _____</p>	
<p>43. Signature of registrar: _____</p>	
<p>44. Signature of informant: _____</p>	
<p>45. Signature of witness: _____</p>	
<p>46. Signature of funeral home: _____</p>	
<p>47. Signature of coroner: _____</p>	
<p>48. Signature of medical examiner: _____</p>	
<p>49. Signature of health officer: _____</p>	
<p>50. Signature of registrar: _____</p>	
<p>51. Signature of informant: _____</p>	
<p>52. Signature of witness: _____</p>	
<p>53. Signature of funeral home: _____</p>	
<p>54. Signature of coroner: _____</p>	
<p>55. Signature of medical examiner: _____</p>	
<p>56. Signature of health officer: _____</p>	
<p>57. Signature of registrar: _____</p>	
<p>58. Signature of informant: _____</p>	
<p>59. Signature of witness: _____</p>	
<p>60. Signature of funeral home: _____</p>	
<p>61. Signature of coroner: _____</p>	
<p>62. Signature of medical examiner: _____</p>	
<p>63. Signature of health officer: _____</p>	
<p>64. Signature of registrar: _____</p>	
<p>65. Signature of informant: _____</p>	
<p>66. Signature of witness: _____</p>	
<p>67. Signature of funeral home: _____</p>	
<p>68. Signature of coroner: _____</p>	
<p>69. Signature of medical examiner: _____</p>	
<p>70. Signature of health officer: _____</p>	
<p>71. Signature of registrar: _____</p>	
<p>72. Signature of informant: _____</p>	
<p>73. Signature of witness: _____</p>	
<p>74. Signature of funeral home: _____</p>	
<p>75. Signature of coroner: _____</p>	
<p>76. Signature of medical examiner: _____</p>	
<p>77. Signature of health officer: _____</p>	
<p>78. Signature of registrar: _____</p>	
<p>79. Signature of informant: _____</p>	
<p>80. Signature of witness: _____</p>	
<p>81. Signature of funeral home: _____</p>	
<p>82. Signature of coroner: _____</p>	
<p>83. Signature of medical examiner: _____</p>	
<p>84. Signature of health officer: _____</p>	
<p>85. Signature of registrar: _____</p>	
<p>86. Signature of informant: _____</p>	
<p>87. Signature of witness: _____</p>	
<p>88. Signature of funeral home: _____</p>	
<p>89. Signature of coroner: _____</p>	
<p>90. Signature of medical examiner: _____</p>	
<p>91. Signature of health officer: _____</p>	
<p>92. Signature of registrar: _____</p>	
<p>93. Signature of informant: _____</p>	
<p>94. Signature of witness: _____</p>	
<p>95. Signature of funeral home: _____</p>	
<p>96. Signature of coroner: _____</p>	
<p>97. Signature of medical examiner: _____</p>	
<p>98. Signature of health officer: _____</p>	
<p>99. Signature of registrar: _____</p>	
<p>100. Signature of informant: _____</p>	

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 8515

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Mrs Rose Devlin</u>		2. DATE OF DEATH <u>10-4-50.</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Balto.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore 13. 1-05</u>	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <u>325 S. Madenia St. Balto.</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>M.</u>	8. DATE OF BIRTH <u>3-9-02</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		9. AGE (In years, last birthday) <u>48</u>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>John Gorecki</u>		12. CITIZEN OF WHAT COUNTRY?	
14. MOTHER'S MAIDEN NAME <u>Rozalia Winczowski</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>215-14-6768</u>		17. INFORMANT ADDRESS <u>William L. Devlin 325 S Madenia St</u>	

18. <u>592x</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH <u>Uremia - Renal Insu</u>	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES	<u>fficiency</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	<u>Chronic Glomerulo-Nephritis</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10-3-1950</u> to <u>10-4-1950</u> , that I last saw the deceased alive on <u>10-4-1950</u> , and that death occurred at <u>6:15 p.m.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>C. J. Castellano</u> M. D.		23B. ADDRESS <u>Bon Secours Hosp.</u>		23C. DATE SIGNED <u>10-4-50.</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>Oct 7-1950</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		25. FUNERAL DIRECTOR <u>George A. Weber</u>		ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR <u>OCT-5-1950</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR ADDRESS	

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

100

100

RECEIVED THE NATIONAL ARCHIVES  
JAN 10 1964

100



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>MATILOA BAKER</b>			2. DATE OF DEATH <b>OCT. 4, 1950</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD</b> B. COUNTY _____		
b. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>2901 BAYONNE AVE</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <b>BALTO.</b> <b>27-06</b>		
c. Length of stay in Baltimore <b>LIFE</b>			d. STREET ADDRESS (If rural, give location) <b>2901 BAYONNE AVE</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>AUG 31, 1859</b>		9. AGE (In years last birthday) <b>91</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
13. FATHER'S NAME <b>JOHN ARNOLD</b>			14. MOTHER'S MAIDEN NAME <b>REBECCA HAMMOND</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>MRS. R. EMINIZER SAME</b>		

18. <b>199.8</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Cerebrovascular primary site</i> <i>undeter mined</i>		<b>12 mo.</b>
ANTECEDENT CAUSES		(B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO		
II		(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>① Hypertension with Cardiac vascular changes</i> <i>② Arteriosclerosis</i>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>June 12, 1947</u> , to <u>3 Oct 1950</u> , that I last saw the deceased alive on <u>3 Oct 1950</u> , and that death occurred at <u>12:14 A.M.</u> , from the causes and on the date stated above.				
23a. SIGNATURE <i>John C. Blume</i>	M. D.	23b. ADDRESS <i>5600 Hampden Rd</i>	23c. DATE SIGNED <i>5 Oct 1950</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>10-6-1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>	24d. LOCATION (City, town, or county) <b>BALTO</b>	(State) <b>MD.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT-5-1950</b>	REGISTRAR'S SIGNATURE <i>William H. Jenkins</i>	25. FUNERAL DIRECTOR ADDRESS <b>H. W. JENKINS &amp; SONS 4905 YORK RD</b>		

MEDICAL CERTIFICATION

Correct age is especially important

1/2 note that primary side can not be determined, however

If possible, please state

a more definite anatomical

location of the malignant tumor



## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EUGENE

THOMAS WATTS

2. DATE  
OF  
DEATH

10-4-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

ST. AGNES HOSPITAL

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2727 MUSHER ST

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

1-3-1873

9. AGE (in years  
last birthday)

77

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Cabinetmaker

10B. KIND OF BUSINESS OR  
INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Balt., Md

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

THOMAS E Watts

14. MOTHER'S MAIDEN NAME

REBECCA CORRELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

(If yes, give war or dates of service)

L

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

Hospital

ADDRESS

18. 151X

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## CAUSE OF DEATH

(A) Curcuma of Stomach.  
DUE TO C metastasis to liver.  
(B) And retroperitoneal nodes.  
DUE TO  
(C)INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Outwio delantre C.V.D.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 10-3-50, 19, to 10-4-50, 19, that I last saw the  
deceased alive on 10-4-50, 19, and that death occurred at 12:30 AM from the causes and on the date stated above.

23A. SIGNATURE

William T. Hall Jr.

M. D.

23B. ADDRESS

St. Agnes Hosp.

23C. DATE SIGNED

10-4-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct 7 1950

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Balt., Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William T. Hall Jr.

25. FUNERAL DIRECTOR

ADDRESS

Henry W. Jenkins - 4905 York Rd

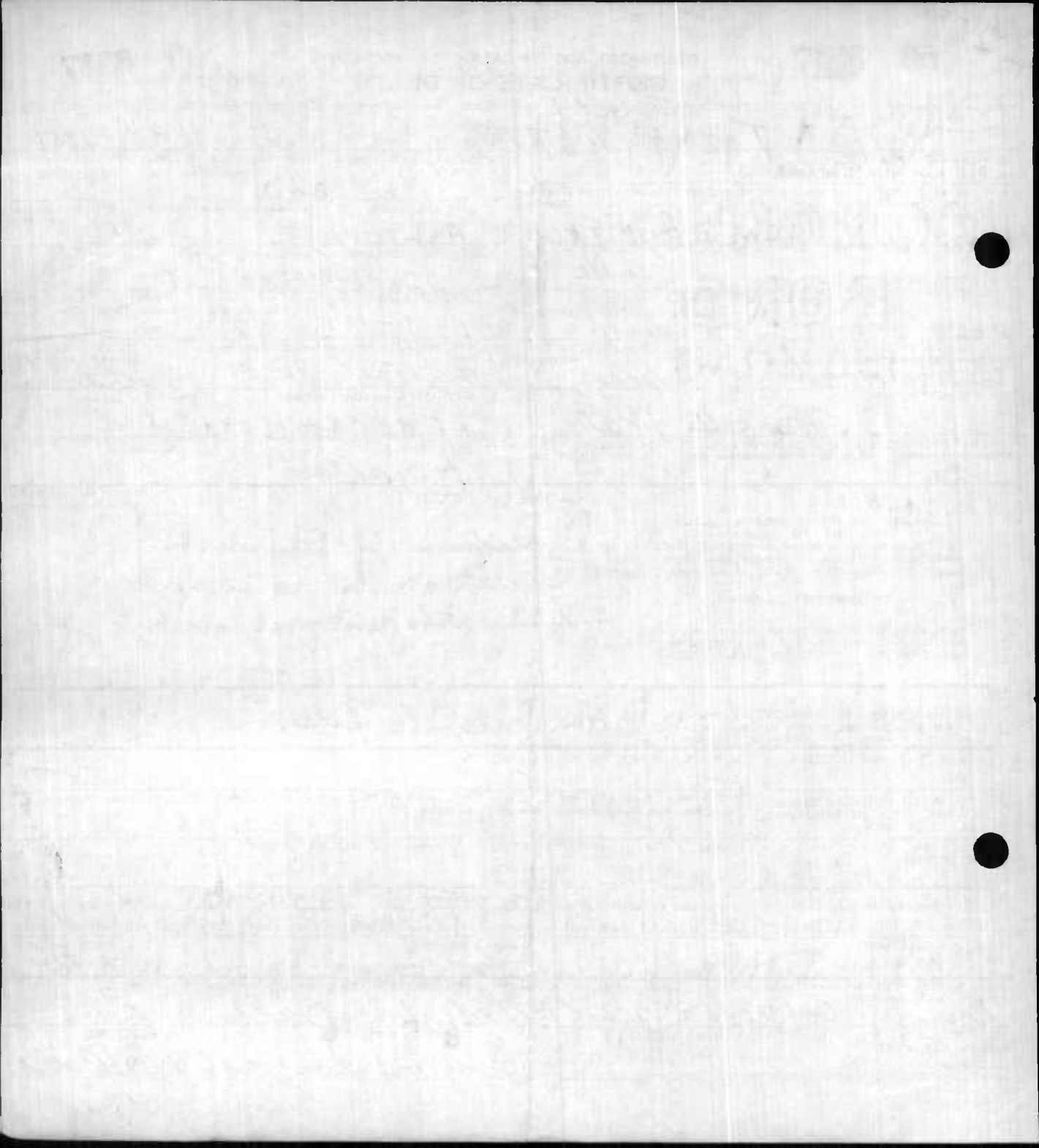
OCT-5-1950

VS 150

046B

MEDICAL CERTIFICATION

correct age



630  
633 50 8518  
DERITA - D. ERADITA

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ROSE DERITA, ROSE OR D'ERADITA</b>			2. DATE OF DEATH <b>10-4-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>1113 Grand St</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>11-2-1896</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Year Months: Days <b>11 2</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>	
13. FATHER'S NAME <b>SALVATORE DIPIPA</b>			12. CITIZEN OF WHAT COUNTRY? <b>ITALIAN</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		
18. <b>420.1.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>MYOCARDIAL INFARCTION</b> <b>24 hrs.</b> DUE TO (B) <b>GENERALIZED ARTERIO-SCLEROSIS WITH</b> <b>HYPERTENSION.</b>			INTERVAL BETWEEN ONSET AND DEATH		
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>			19B. MAJOR FINDINGS OF OPERATION		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>10-3</b> , 19 <b>50</b> , to <b>10-4</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>10-4</b> , 19 <b>50</b> , and that death occurred at <b>9:20 AM.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Wallace E. Buttich</b>			23B. ADDRESS <b>Union Memorial Hospital</b>		
23C. DATE SIGNED <b>4 Oct 1950</b>			24. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>10-7-50</b>		
24C. LOCATION (City, town, or county) (State) <b>Baltimore</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>		
25. FUNERAL RECEIVED BY LOCAL REGISTRAR <b>13244-150</b>			25. FUNERAL DIRECTOR <b>Frank Della Rose</b>		
REGISTRAR'S SIGNATURE <b>W. E. Buttich</b>			ADDRESS <b>322 S. High St</b>		

VS 150

OCT-9 1950

94a

PROSECUTION'S EXHIBIT

VICTIM'S STATEMENT

10-1-77  
10-1-77  
10-1-77

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Otis Daniel*

2. DATE  
OF  
DEATH

*Oct. 1, '50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*JONES HOPKINS HOSPITAL*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore - 19-02*

D. STREET ADDRESS (If rural, give location)

*126 E. Mount St*

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*Male*

6. COLOR OR RACE

*Negro*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Married*

8. DATE OF BIRTH

*8-13-03*

9. AGE (In years last birthday)

*47*

10. Under 1 Year Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)

*Laborer*

10B. KIND OF BUSINESS OR INDUSTRY

*Junk yard*

11. BIRTHPLACE (State or foreign country)

*Rock Hill S.C.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*George Daniel*

14. MOTHER'S MAIDEN NAME

*Sarah Harris*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*JONES HOPKINS HOSPITAL*

18. *521X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*Lung abscess*

INTERVAL BETWEEN ONSET AND DEATH

*8 wks*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *Sept. 28, 1950* to *Oct 1, 1950* that I last saw the deceased alive on *Oct 1, 1950* and that death occurred at *2:30* p.m., from the causes and on the date stated above.

23A. SIGNATURE

*Victor G. McFusick M.D.*

23B. ADDRESS

*JONES HOPKINS HOSPITAL*

23C. DATE SIGNED

*Oct 2, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*10-7-1950*

24C. NAME OF CEMETERY OR CREMATORY

*Wt. Calvary Cem.*

24D. LOCATION (City, town, or county) (State)

*Cedar Hill Md.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*OCT-5-1950*

*William H. Williams*

25. FUNERAL DIRECTOR

*Miss Katie Williams*

ADDRESS

*322 N. Howard St*

VS 150

*97068*

*114d*

MEDICAL CERTIFICATION

Oct 20

Continued

1911  
Oct 21

Had three letters

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. *50-18520*

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Russell Holley*

2. DATE  
OF  
DEATH

*10/2/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*Providence*

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*Providence Hospital*

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

*M*

6. COLOR OR RACE

*C*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Married*

8. DATE OF BIRTH

*Sept 9, 1875*

9. AGE (In years last birthday)

*55*

10 Under 1 Year Months-Days

11 Under 24 Hours Hours-Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Porter*

10B. KIND OF BUSINESS OR INDUSTRY

*Steel Plant*

11. BIRTHPLACE (State or foreign country)

*Maryville, N. C.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Lathimore Holley*

14. MOTHER'S MAIDEN NAME

*Mrs. Holley*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

*No.*

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS *1908 W. Lexington St.*

18. *443X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*Cerebral Thrombosis  
H. H. I*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *September 30, 1950*, to *October 2, 1950*, that I last saw the deceased alive on *Oct. 2, 1950*, and that death occurred at *3:45 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*H. Nicolas*

23B. ADDRESS

*Providence Hospital*

23C. DATE SIGNED

*10/2/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

*10-6-1950*

24C. NAME OF CEMETERY OR CREMATORY

*Wt. Auburn Cem. Balto.*

24D. LOCATION (City, town, or county) (State)

*Md.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

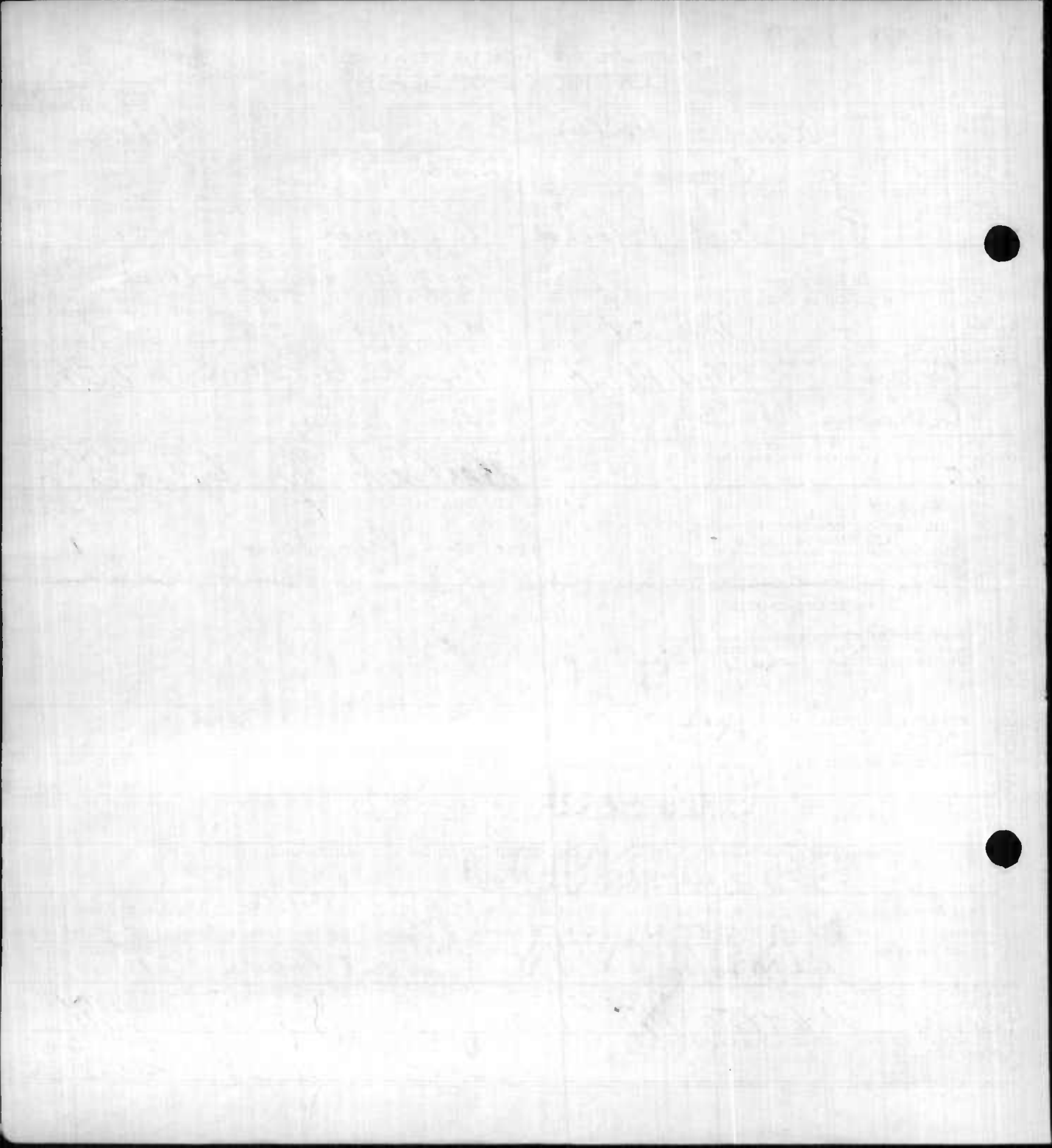
ADDRESS

*Oct-5-1950*

*Washington, D.C.*

*Mrs. Kate R. Williams*

*Schweitzer*



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

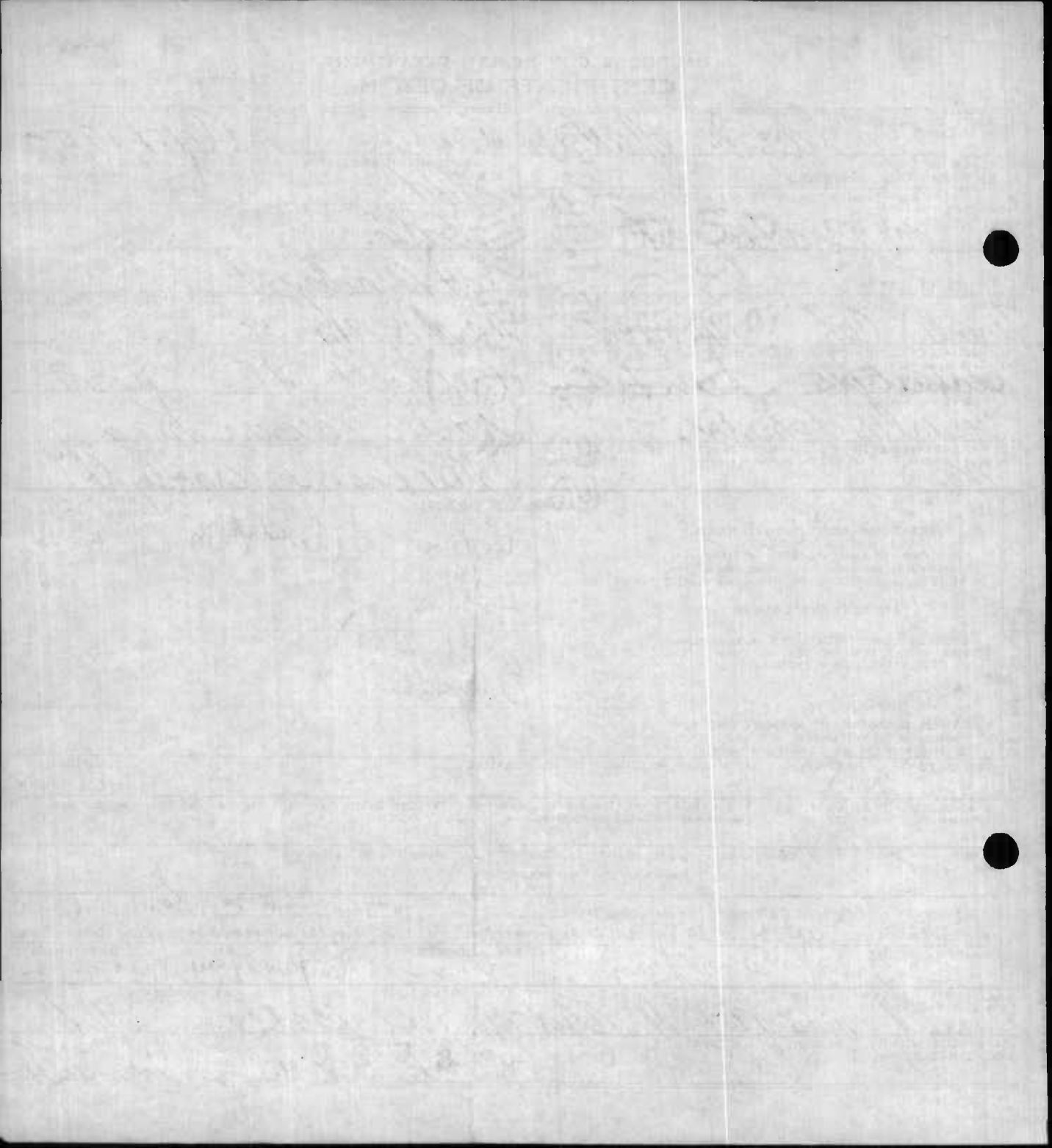
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Ida M Madree Quinn</i>		2. DATE OF DEATH <i>Oct. 1, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>804 Bradley St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto.</i>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <i>804 Bradley St. 17-03</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>March 18, 1912</i>
10A. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Seamstress</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Dress Factory</i>	
11. BIRTHPLACE (State or foreign country) <i>Crestwell N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Brown</i>		14. MOTHER'S MAIDEN NAME <i>Sallie Brown King</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Sallie Brown Bradley St. 804</i>		ADDRESS _____	

<p>18. <i>241X</i></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p align="center"><b>CAUSE OF DEATH</b></p> <p><i>Cardiac dilatation</i></p> <p>(A) _____ DUE TO _____</p> <p><i>Asthma</i></p> <p>(B) _____ DUE TO _____</p> <p><i>Bronchitis</i></p> <p>(C) _____</p>	<p>INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i></p>

19A. DATE OF OPERATION <i>None</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1940</i> to <i>Sept. 30, 1950</i> , that I last saw the deceased alive on <i>Sept. 30, 1950</i> , and that death occurred at <i>6A</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Robert L. Levy</i>		23B. ADDRESS <i>2322 Canton Place</i>		23C. DATE SIGNED <i>10-4-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-5-1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>W.F. Culver Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		25. FUNERAL DIRECTOR <i>Miss Katie R. Williams</i>		ADDRESS <i>Schneider St.</i>	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*John P. Sataitis*

2. DATE  
OF  
DEATH

*10/4/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

*Maryland 18-03*

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

*914 Hollins St.*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore*

C. Length of stay in Baltimore

*50 yrs*

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

*914 Hollins St.*

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months: Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

*Unknown 1874 76*

*Sailor*

*Married*

11. BIRTHPLACE (State or foreign country)

*Lithuania*

12. CITIZEN OF WHAT COUNTRY?

*✓*

13. FATHER'S NAME

*Peter Sataitis*

14. MOTHER'S MAIDEN NAME

*Unknown*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Mrs Agnes Sataitis 914 Hollins St*

18. *422.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Arteriosclerotic cardiovascular disease*

*unknown*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_  
DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Aug. 4, 1950* to *Oct. 4, 1950*, that I last saw the deceased alive on *Oct. 4, 1950*, and that death occurred at *6:00 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Abraham B. Hurwitz*

23B. ADDRESS

*3049 W. North Ave.*

23C. DATE SIGNED

*Oct. 5, 1950*

24A. BURIAL, CREMATION REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

*Burial*

*10/7/50*

*Holy Redeemer Cem 4430 Belair Rd.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*OCT-5-1950*

VS 150

*John J. Cowan & Son 901 093d St.*

MEDICAL CERTIFICATION

correct age is 13

NOT A MEDICAL EXAMINER'S CASE

*R. Fisher*

M.D.

CHIEF OR ASST. MEDICAL EXAMINER



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 8523

BIRTH NO. 5530

1. NAME OF DECEASED (Type or Print) <b>DANIEL T. SMITH</b>		2. DATE OF DEATH <b>OCT. 4, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE CITY</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b> (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 18 - 27-09</b>	
c. Length of stay in Baltimore <b>LIFE</b>		O. STREET ADDRESS (If rural, give location) <b>9414 MARBLE HALL ROAD</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>AUG. 5, 1893</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Tailoring CO. (W)</b>	9. AGE (In years last birthday) <b>57</b>
13. FATHER'S NAME <b>ANTON J. SMITH</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>217-01-9310</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>217-01-9310</b>	
17. INFORMANT <b>4414 Marble Hall Rd.</b>		18. MOTHER'S MAIDEN NAME <b>MARY KAVANAUGH</b>	
19. INFORMANT <b>Mrs. Isabel B. Smith</b>		20. INFORMANT <b>Mrs. Isabel B. Smith</b>	

18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH  (A) <b>MYOCARDIAL INFARCTION</b> DUE TO  (B) <b>CORONARY OCCLUSION</b> DUE TO  (C) <b>ASHD</b>	INTERVAL BETWEEN ONSET AND DEATH  <b>?</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

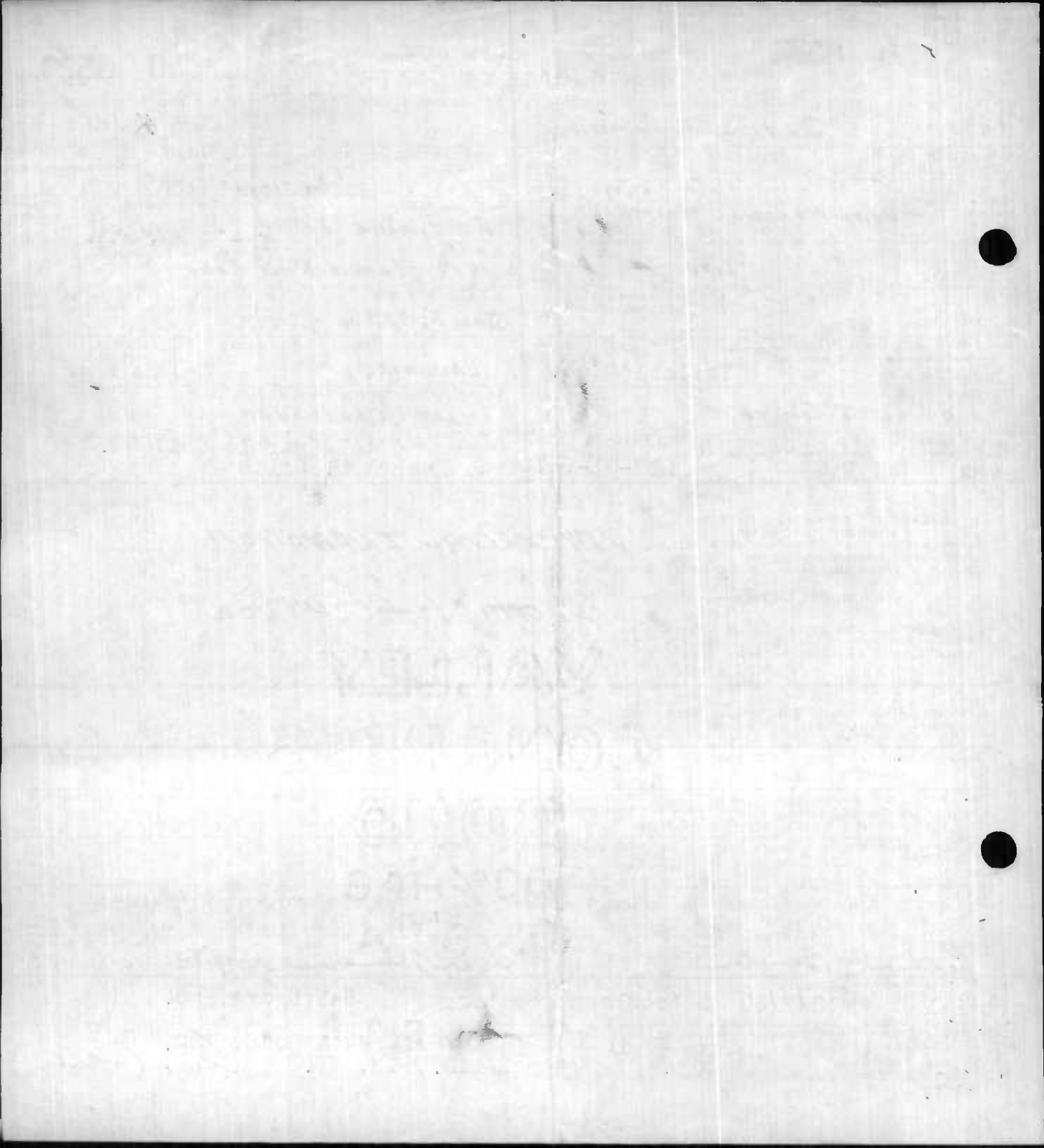
19A. DATE OF OPERATION <b>7</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **OCT. 1**, 1950, to **OCT. 4**, 1950, that I last saw the deceased alive on **OCT. 4**, 1950, and that death occurred at **5:22 AM.**, from the causes and on the date stated above.

23A. SIGNATURE **Richard Beach** M. D. 23B. ADDRESS **Union Memorial Hospital** 23C. DATE SIGNED **10-4-50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **burial** 24B. DATE **10/7/50** 24C. NAME OF CEMETERY OR CREMATORY **Woodlawn cemetery** 24D. LOCATION (City, town, or county) (State) **Baltimore, Md.**

DATE RECEIVED BY LOCAL REGISTRAR **OCT-5-1950** REGISTRAR'S SIGNATURE **Henry Sander & Sons, Inc.** ADDRESS **BALTO., 13, MD.**



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Mr. James Thomas Jeffords</b>		2. DATE OF DEATH <b>October 4, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>24-04</b>	
D. LENGTH OF STAY IN BALTIMORE <b>40yr.</b>		D. STREET ADDRESS (If rural, give location) <b>504 E. Randall Street</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug. 24, 1891</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe Fitter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unemployed</b>	
13. FATHER'S NAME <b>Taylor P. Jeffords</b>		14. MOTHER'S MAIDEN NAME <b>Mary I. Hutson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-01-4029</b>	
		17. INFORMANT <b>504 E. Randall Street Mrs Agnes V. Jeffords</b>	

18. **430.0** CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Multiple peripheral embolism**  
DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Bacterial endocarditis**  
DUE TO

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **✓** 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **10/2/**, 19**50**, to **10/4/**, 19**50**, that I last saw the deceased alive on **10/4/**, 19**50**, and that death occurred at **12:02AM** from the causes and on the date stated above.

23A. SIGNATURE **B. B. Velaz** 23B. ADDRESS **1400 N. Caroline St.** 23C. DATE SIGNED **10/4/50**

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24B. DATE <b>10/7/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St. Peters Catholic Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Columbia, S.C.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT-5-1950</b>		25. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS, INC.</b> <b>BALTO., 13, MD.</b>	

11

1

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**EVELYN MAY FISHER**

2. DATE  
OF  
DEATH

**Oct. 3, 1950**

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**Mount Convalescing Home**

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE

b. COUNTY

**Maryland**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore**

d. STREET ADDRESS (If rural, give location)

**2743 Tivoly Avenue**

5. SEX

**F**

6. COLOR OR RACE

**W**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Married**

8. DATE OF BIRTH

**May 7, 1896**

9. AGE (in years last birthday)

**54**

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Seamstress**

10b. KIND OF BUSINESS OR INDUSTRY

**Dairyming Co.**

11. BIRTHPLACE (State or foreign country)

**South Carolina**

12. CITIZEN OF WHAT COUNTRY?

**USA**

13. FATHER'S NAME

**Charles Kidd**

14. MOTHER'S MAIDEN NAME

**Lena Platt**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no unknown) (If yes, give war or dates of service)

**no**

16. SOCIAL SECURITY NO.

**213-01-6945**

17. INFORMANT

**Mrs. Howard A. McCollum**

ADDRESS

**2743 Tivoly Avenue**

18. **153X**

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Carcinoma of sigmoid**

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Carcinoma of sigmoid**

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

**Feb 1950**

19b. MAJOR FINDINGS OF OPERATION

**Carcinoma of sigmoid**

20. AUTOPSY?

YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Aug 1**, 19**50**, to **Oct 3**, 19**50**, that I last saw the deceased alive on **10/2**, 19**50**, and that death occurred at **10** **4** m., from the causes and on the date stated above.

23a. SIGNATURE

**Harold W. Wilson**

23b. ADDRESS

**5721 Hallway Ave**

23c. DATE SIGNED

**10/4/50**

24a. BURIAL, CREMATION, REMOVAL (Specify)

**burial**

24b. DATE

**10/6/50**

24c. NAME OF CEMETERY OR CREMATORY

**Moreland Memorial Cem. Baltimore, Md.**

24d. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

**OCT-5-1950**

REGISTRAR'S SIGNATURE

**Harold W. Wilson**

25. FUNERAL DIRECTOR

**HARRY SANDER & SONS, INC.**

ADDRESS

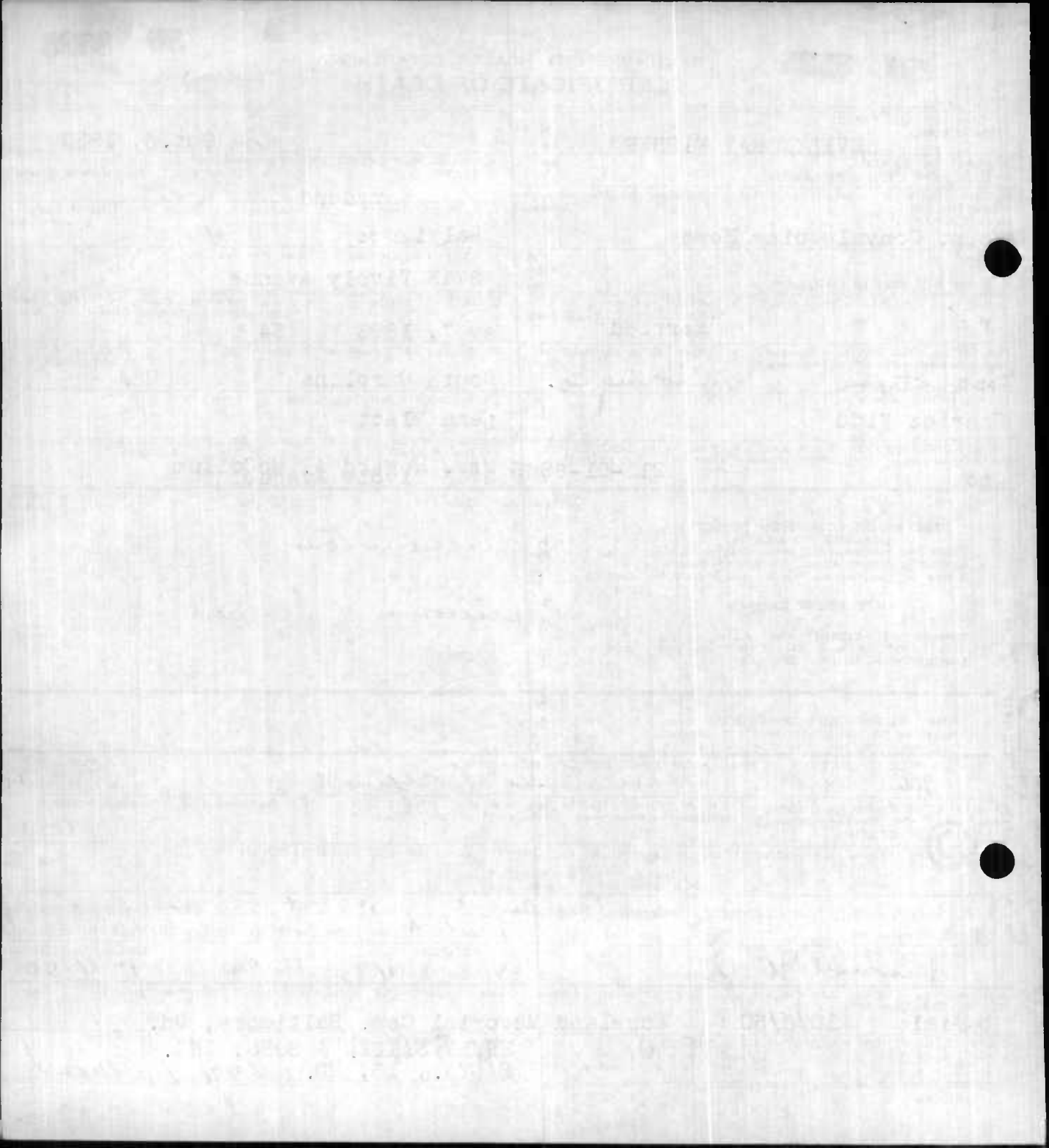
**BALTO., 13, MD. Perry F. Sander**

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**633 4G**

**0462**

correct age is especially important





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>THELMA M. ECKMAN</b>			2. DATE OF DEATH <b>10-4-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Lutheran Hosp. of MD.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hosp. of MD.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>City</b> <b>5300</b>		
5. Length of stay in Baltimore <b>Life!</b>			D. STREET ADDRESS (If rural, give location) <b>328 First Ave. Sandown #27</b>		
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Dec. 5, 1932</b>		9. AGE (In years last birthday) <b>17 18</b>
10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Howard A. Eckman</b>			14. MOTHER'S MAIDEN NAME <b>Madeleine Shelton</b> ✓		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT ADDRESS <b>Howard A. Eckman 328 First Ave. Sandown</b>		

18. <b>401.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <b>Subacute Bacterial Endocarditis</b> DUE TO (B) <b>Rheumatic Heart Disease</b> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION <b>✓</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>August 28</b> , 19 <b>50</b> , to <b>Oct 4</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>Oct. 4</b> , 19 <b>50</b> , and that death occurred at <b>3:05 P.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Jos. C. Macapanpan</b>		23B. ADDRESS <b>Lutheran Hosp. of MD.</b>		23C. DATE SIGNED <b>Oct. 4, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-7-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25. FUNERAL DIRECTOR ADDRESS <b>George F. Schwab 2001 Rudwick Ave.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT-5-1950</b>		REGISTRAR'S SIGNATURE <b>Walter H. Williams</b>		25. FUNERAL DIRECTOR ADDRESS <b>George F. Schwab 2001 Rudwick Ave.</b>	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. 50 8527

1. NAME OF DECEASED (Type or Print) <b>James Brown</b>		2. DATE OF DEATH <b>Oct. 3, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>1012 N. Arlington Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>1012 N. Arlington Ave.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 15, 1891</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>School</b>	9. AGE (In years last birthday) <b>59</b>
13. FATHER'S NAME <b>James Brown, Sr.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
16. SOCIAL SECURITY NO. _____		14. MOTHER'S MAIDEN NAME <b>Fannie Brown</b>	
17. INFORMANT <b>Mrs. Hannah Brown</b>		ADDRESS <b>1012 N. Arlington</b>	

<b>MEDICAL CERTIFICATION</b>	18. <b>592x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Chronic Glomerulo Nephritis</b> DUE TO		
	(C) _____		
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

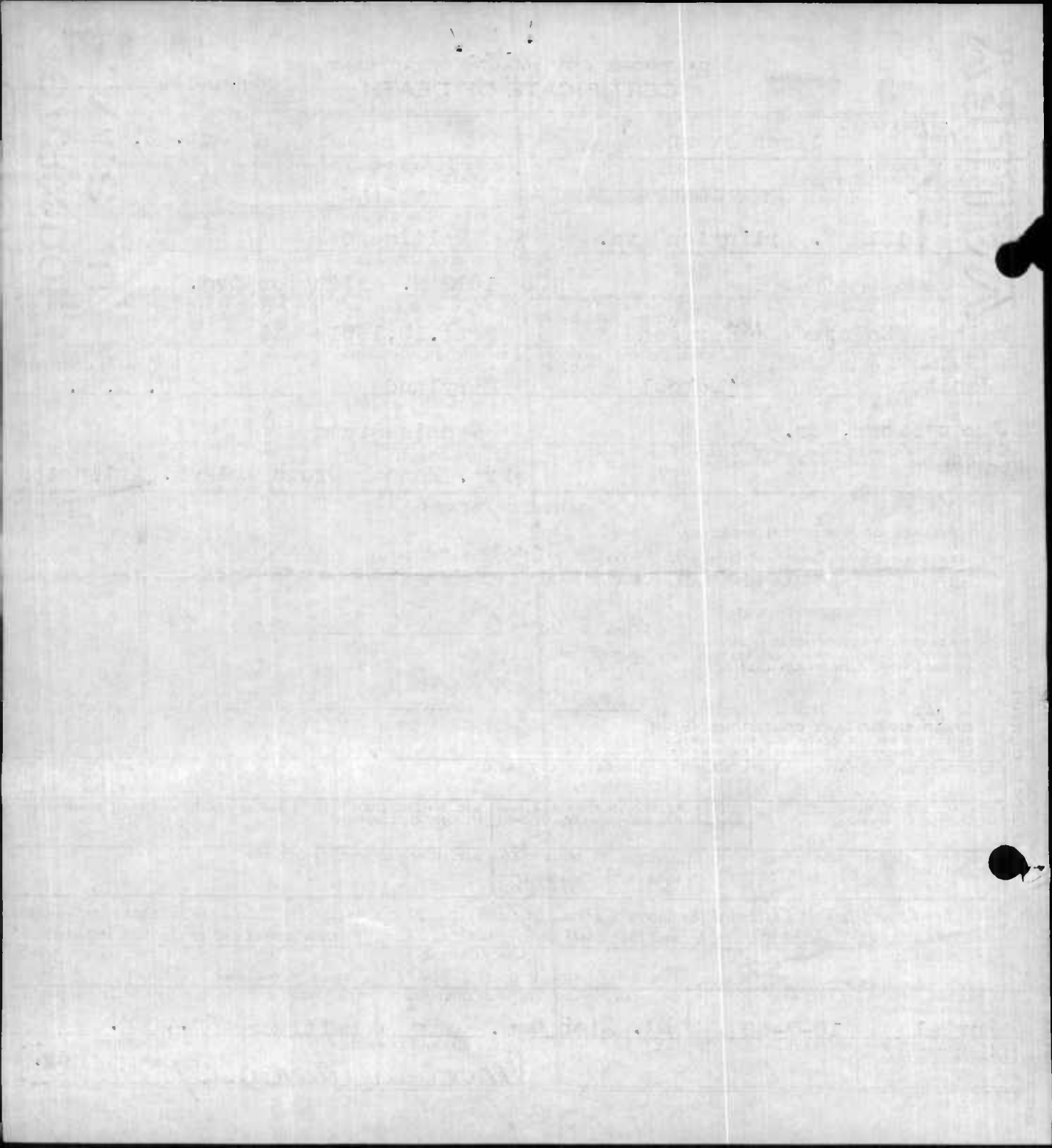
19A. DATE OF OPERATION <b>10/3</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7/10</u> , 1950, to <u>10/3</u> , 1950, that I last saw the deceased alive on <u>10/2</u> , 1950, and that death occurred at <u>8:10</u> A. m., from the causes and on the date stated above.					
23A. SIGNATURE <b>J. Preston Grant</b>		23B. ADDRESS <b>601 N. Gerontow</b>		23C. DATE SIGNED <b>10/5/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-7-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md.</b>		25. FUNERAL DIRECTOR <b>Mr. Francis A. Hensley</b>		ADDRESS <b>578 W. Biddle St.</b>	

OCT-5-1950

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Catherine Egenhoefer,

2. DATE  
OF  
DEATH Oct. 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)  
A. STATE Md. B. COUNTYB. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

2859 Chesterfield Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)  
Baltimore, 27-01

D. STREET ADDRESS (If rural, give location)

2859 Chesterfield Ave.,

E. Length of stay in Baltimore

71 years

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Widow

8. DATE OF BIRTH

July 9, 1861

9. AGE (In years  
last birthday)

89

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

(last name)

Wellein,

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.  
none

17. INFORMANT

ADDRESS

Joseph Egenhoefer, 2859 Chesterfield Ave.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary occlusion

2 wks.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Coronary insufficiency  
(C) Generalized arteriosclerosis

1 yr.

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1945 to Oct. 3, 1950, that I last saw the  
deceased alive on Oct. 3, 1950, and that death occurred at 11<sup>00</sup> P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

1706 N. Washington St.

10/4/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

Oct. 7, 1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery,

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT-5-1950

VS 150

Intestine Williams

J. L. Lerman

4611 Park Heights Ave.

094a

DIAGNOSTIC

AVIARY

3000

1000

1000

1000

1000



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

2. DATE  
OF  
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

D. STREET ADDRESS (If rural, give location)

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years last birthday)

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Aug 7, 1950 to Oct 2, 1950, that I last saw the deceased alive on Oct 2, 1950 and that death occurred at 11 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

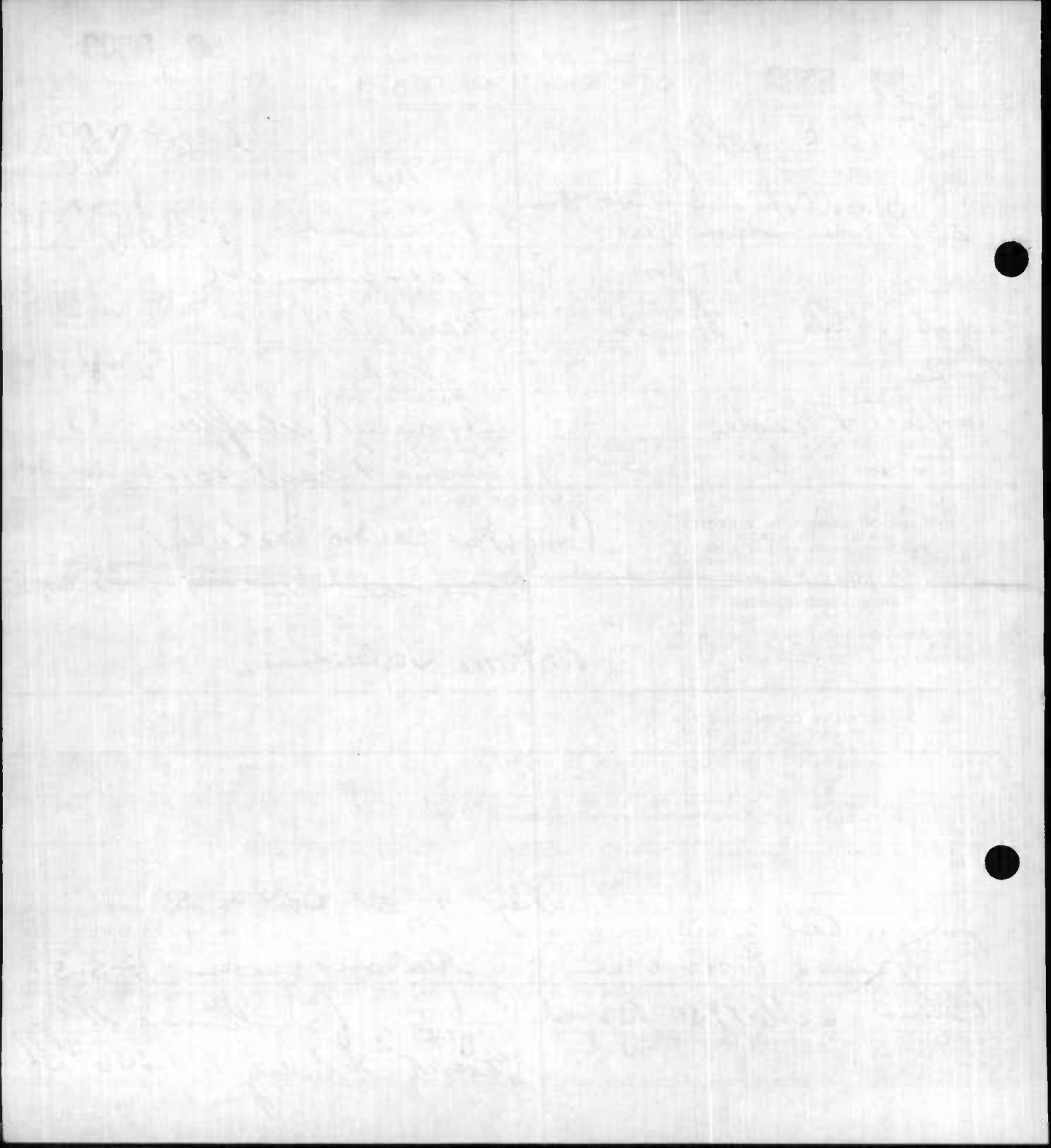
(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

IDA S. WEHNER

2. DATE OF DEATH  
10/4/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
2333 Calverton Hgts. Ave.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
Md.  
B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)  
2333 Calverton Hgts. Ave.

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
widowed

8. DATE OF BIRTH

April 19, 1874

9. AGE (In years, last birthday)

76

If Under 1 Year Months Days  
If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
housewife

10B. KIND OF BUSINESS OR INDUSTRY  
at home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Smith

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Mr. Fred S. Wehner - 2604 Denison St.

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Hypocordial Degeneration & in sufficiency with congestive failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Chronic arterial disease with hypertrophy & hypertension

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.

(C) DUE TO

Generalized arteriosclerosis

Diabetes

20. AUTOPSY?  
YES ☐ NO ☐

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from June 1, 1950 to Oct 4, 1950 that I last saw the deceased alive on Oct 3, 1950, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

24B. DATE

10/6/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT - 5 1950

VS 150

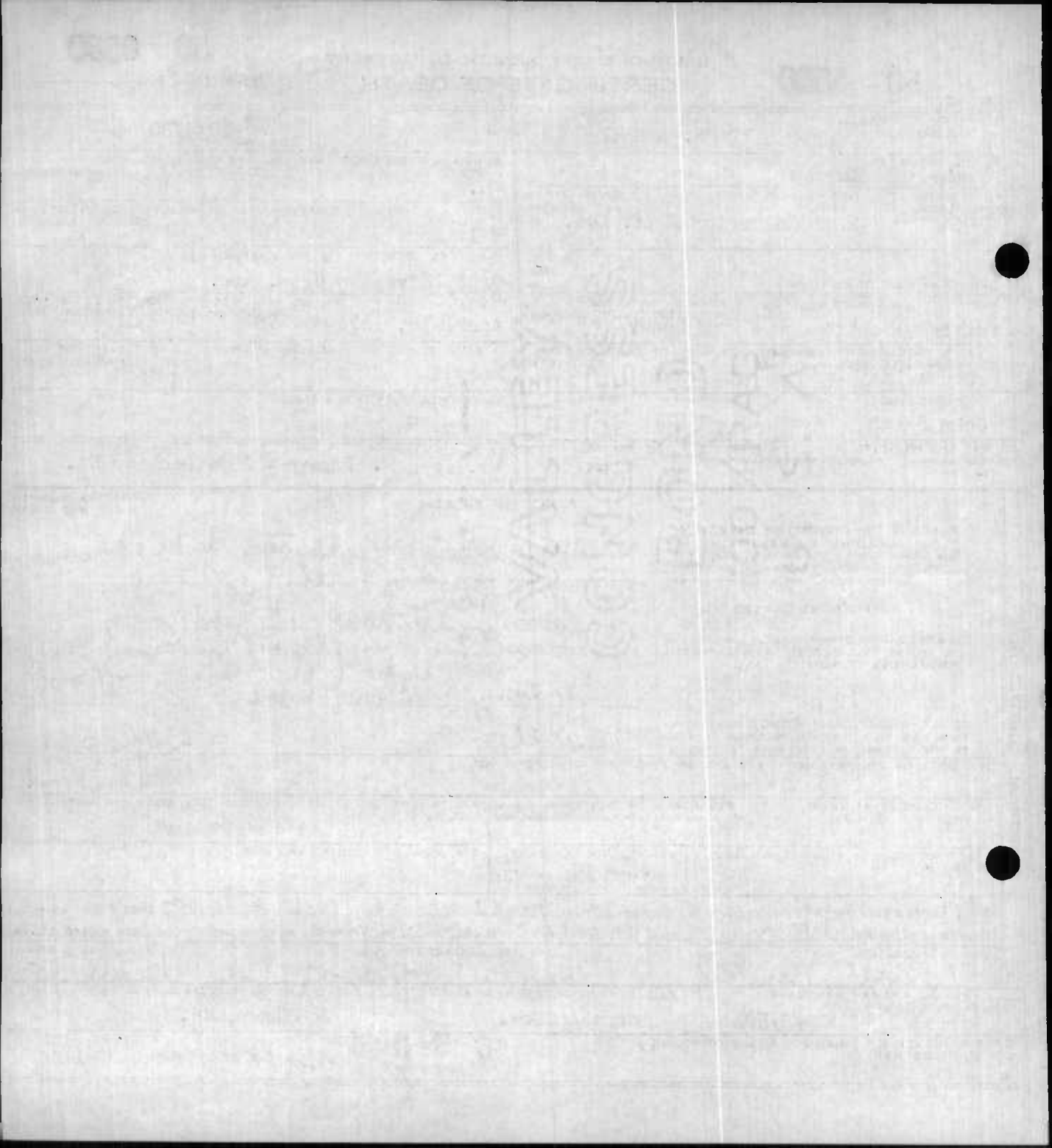
Washington Williams, M.D.

Wm. J. Dickoner & Sons - Balt. Md.

061.0

MEDICAL CERTIFICATION

Correct age is especially important



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

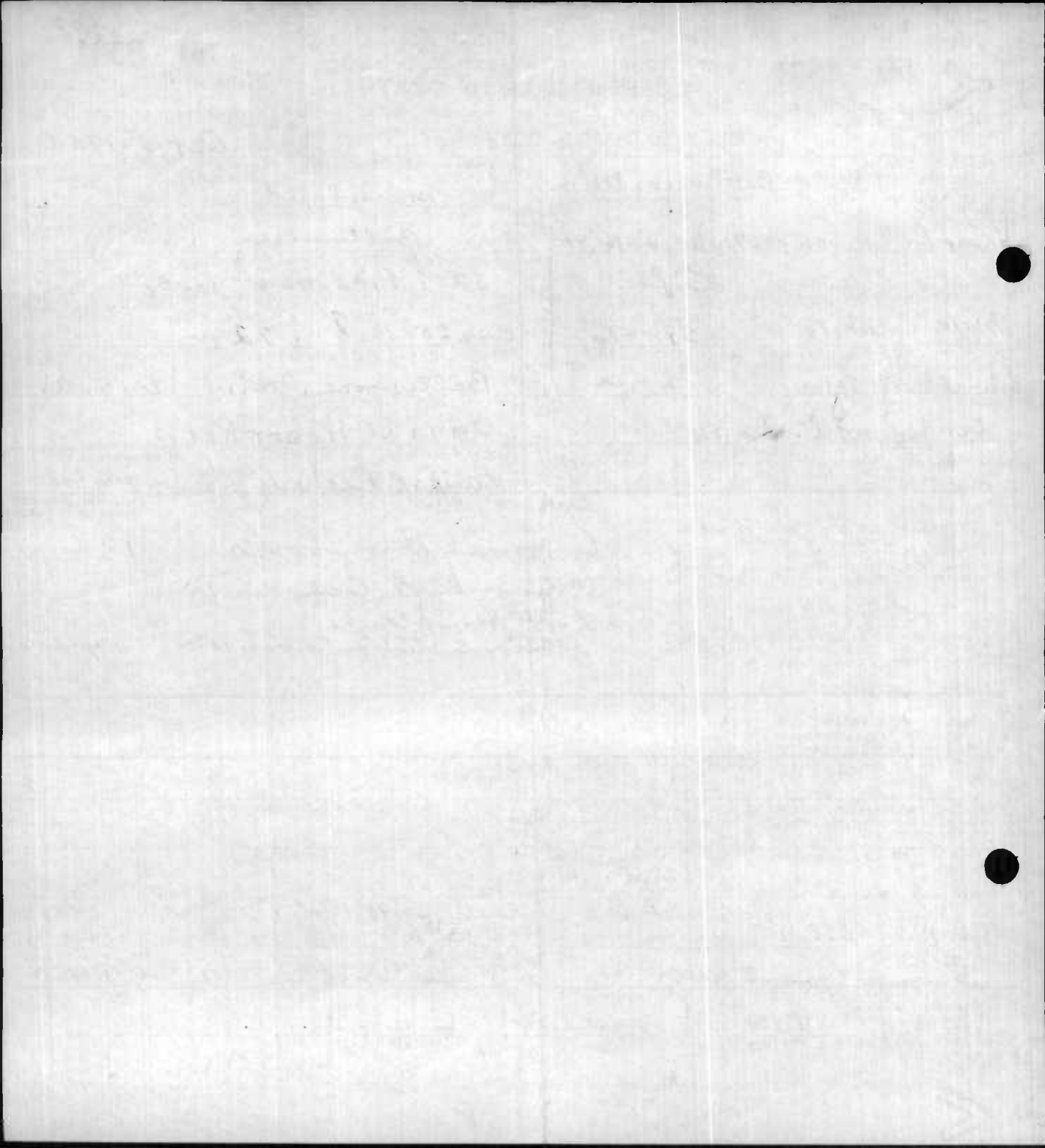
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>FERDINAND CHARLES SMITH</b>		2. DATE OF DEATH <b>Oct 4 - 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore, Md.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Home for Incurables - 700 W. 40th St</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 15-37</b>	
c. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>3209 Piedmont Ave.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Aug 25, 1878</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Teacher</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>	9. AGE (In years last birthday) Months: Days <b>72 yr</b>
13. FATHER'S NAME <b>Ferdinand C. Smith</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no -</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
16. SOCIAL SECURITY NO. <b>no</b>		14. MOTHER'S MAIDEN NAME <b>Anna C. Hoberkorn</b>	
17. INFORMANT <b>Laura E. Fischer R. h. 700 W. 40th St</b>		ADDRESS _____	

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>CAUSE OF DEATH</b> (A) <b>Coronary Thrombosis</b> DUE TO <b>Arteriosclerotic Cardio Vasc Dis.</b> (B) <b>Left Hemiplegia</b> DUE TO <b>Arteriosclerotic Cardio. Vasc. Dis</b> (C) _____	INTERVAL BETWEEN ONSET AND DEATH  <b>12 days</b>  <b>3 years</b>
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>July 1st</b> 1948, to <b>Oct. 4th</b> 1950, that I last saw the deceased alive on <b>Oct. 4th</b> 1950, and that death occurred at <b>3:15 a. m.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>Thomas Conrad Wolf</b>	M. D.	23B. ADDRESS <b>11 E. Chasolt, Baltimore 2 Md.</b>	23C. DATE SIGNED <b>10/4/1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/7/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>Oct 11 - 1950</b>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR <b>2 Km. J. Pickner &amp; Sons - Balto. Md.</b>		





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

H. Earle Rose

2. DATE  
OF  
DEATH

Oct. 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2219 N. Charles Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2219 N. Charles Street

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

March 27, 1900

9. AGE (In years  
last birthday)

50

If Under 1 Year  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
meat cutter - Ret.

10B. KIND OF BUSINESS OR  
INDUSTRY  
Own Business

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Welbourne L. Rose

14. MOTHER'S MAIDEN NAME

Jennie Larmour

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Julia J. Rose, 2219 N. Charles St.

18. 525X CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary fibrosis

Several  
years.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Pulmonary emphysema.

DUE TO

(C) Right-sided heart failure.

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

None.

19A. DATE OF OPERATION

None.

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)  
No Injury.

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December 20, 1945 to September 22, 1950, that I last saw the  
deceased alive on Sept. 22, 1950, and that death occurred at 12 A. m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

11 E. Chase St., Balto. 2, Md.

23C. DATE SIGNED

10.5.50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
burial

24B. DATE

10/7/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine

24D. LOCATION (City, town, or county)

Woodlawn,

Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

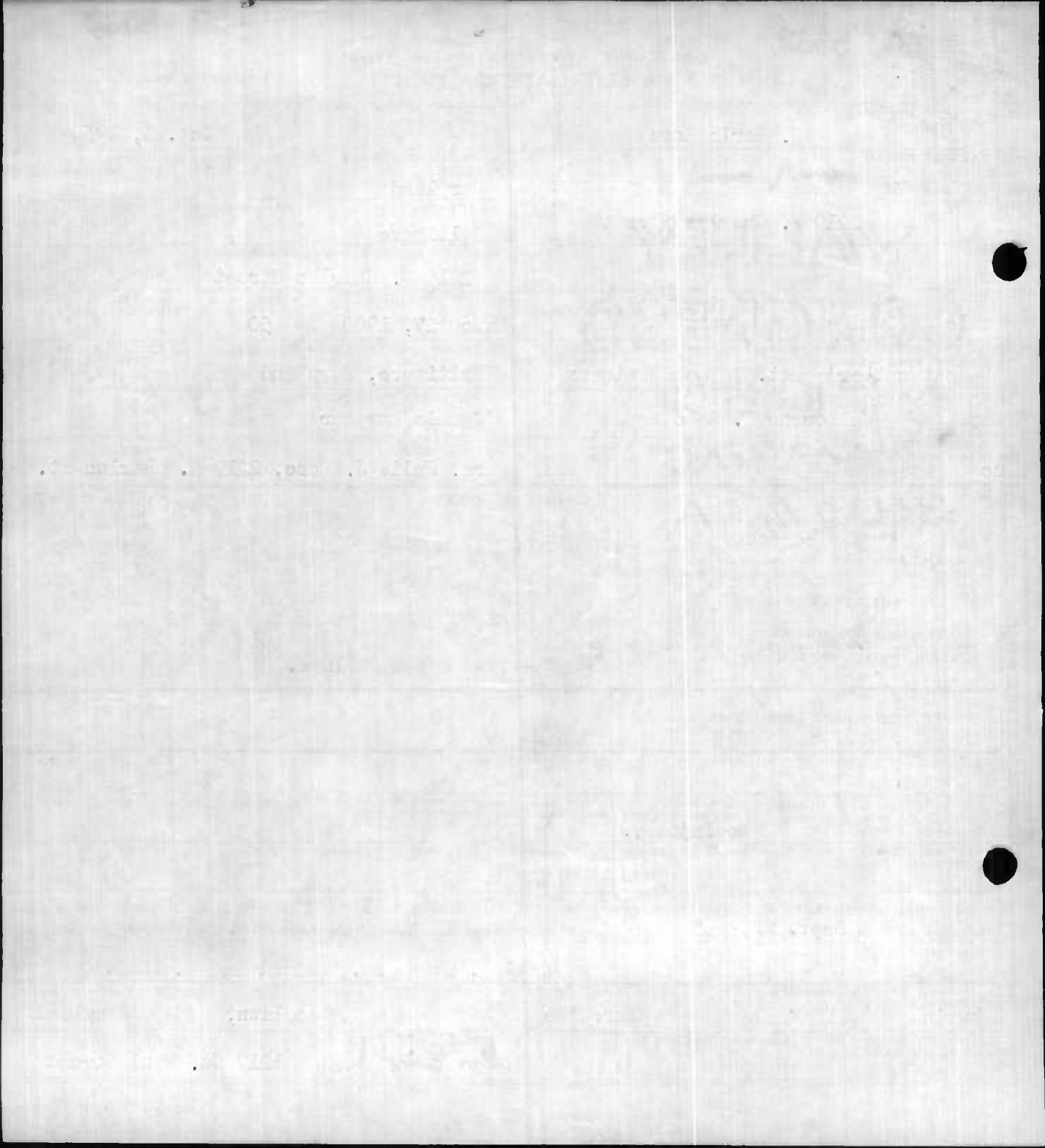
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

26m. Cook, Inc.

1217 St. Paul Street



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Jennie Mae Tompkins

2. DATE  
OF  
DEATH

Oct. 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2005 W. Saratoga Street

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

20-01

D. STREET ADDRESS (If rural, give location)

2005 W. Saratoga Street

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Feb. 14, 1893

9. AGE (In years last birthday)

57

If Under 1 Year Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Warrenton, Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Sam Soaper

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Ralph P. Tompkins, 1615 Annabell Avenue

18. 331X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

(B) Arterio Sclerosis

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from June, 1930, to Oct 4, 1950, that I last saw the deceased alive on Oct 4, 1950, and that death occurred at 1:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

10/7/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FEDERAL DIRECTOR

ADDRESS

Oct-51950

W. H. G. Williams, M.D.

St. M. Cook, Inc. 1217 St. Paul Street

20 220

20 220

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Handwritten text, possibly a signature or name, appearing in the bottom section of the page.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*John B. Jennings*

2. DATE  
OF  
DEATH

*Oct. 3-1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

*660 Pitcher St.*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

*md*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Balto.*

*14-02*

D. STREET ADDRESS (If rural, give location)

*660 Pitcher St*

c. Length of stay in Baltimore

*50*

Yrs.  
Mos.  
Days

5. SEX

*M.*

6. COLOR OR RACE

*C*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*m.*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Genl. Laborer*

10B. KIND OF BUSINESS OR INDUSTRY

*Contractors*

13. FATHER'S NAME

*Unknown*

8. DATE OF BIRTH

*Aug. 8-1880*

9. AGE (In years last birthday) Months: Days Hours: Min.

*70*

11. BIRTHPLACE (State or foreign country)

*West Point Va*

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

*Fannie Allen*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

*216-09-4237*

17. INFORMANT

ADDRESS

*Laurella Jennings - 660 Pitcher St*

18. *442X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Heart Failure*

DUE TO

*Hypertension - Cardiac - Renal*

(B)

DUE TO

*Basal*

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

*none*

19A. DATE OF OPERATION

*none*

19B. MAJOR FINDINGS OF OPERATION

*none*

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

*none*

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

*no*

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

*no*

22. I hereby certify that I attended the deceased from *Oct. 3, 1950*, to *Oct. 3, 1950*, that I last saw the deceased alive on *Oct. 3, 1950*, and that death occurred at *7:30 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

*Wayland T. Jones*

23B. ADDRESS

*1300 N. Fremont*

23C. DATE SIGNED

*10/5/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*B.*

24B. DATE

*10-7-50*

24C. NAME OF CEMETERY OR CREMATORY

*Mt. Auburn Cem*

24D. LOCATION (City, town, or county)

*Balto.*

(State)

*md.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*W. T. Jones*

25. FUNERAL DIRECTOR

ADDRESS

*Samuel W. Sullivan Jr.*

*OCT 5 1950*

*970241011 N. Arlington Ave. 131a*

MEDICAL CERTIFICATION

1973

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. 50-16739

1. NAME OF DECEASED (Type or Print) <u>Arnold Lane</u>		2. DATE OF DEATH <u>Oct 4, 1950</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Ped. H/H 4 E</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>JONES HOPKINS HOSPITAL</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>5300 Wundah, Balto</u>	
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <u>310 Grebe Court</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Child</u>	8. DATE OF BIRTH <u>8-4-50</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (in years last birthday) <u>2</u>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>Bernard Lane</u>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Lula Sessions</u>	
16. SOCIAL SECURITY NO.		17. INFORMATION ADDRESS <u>JONES HOPKINS HOSPITAL</u>	

18. <u>754.4</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Congenital heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

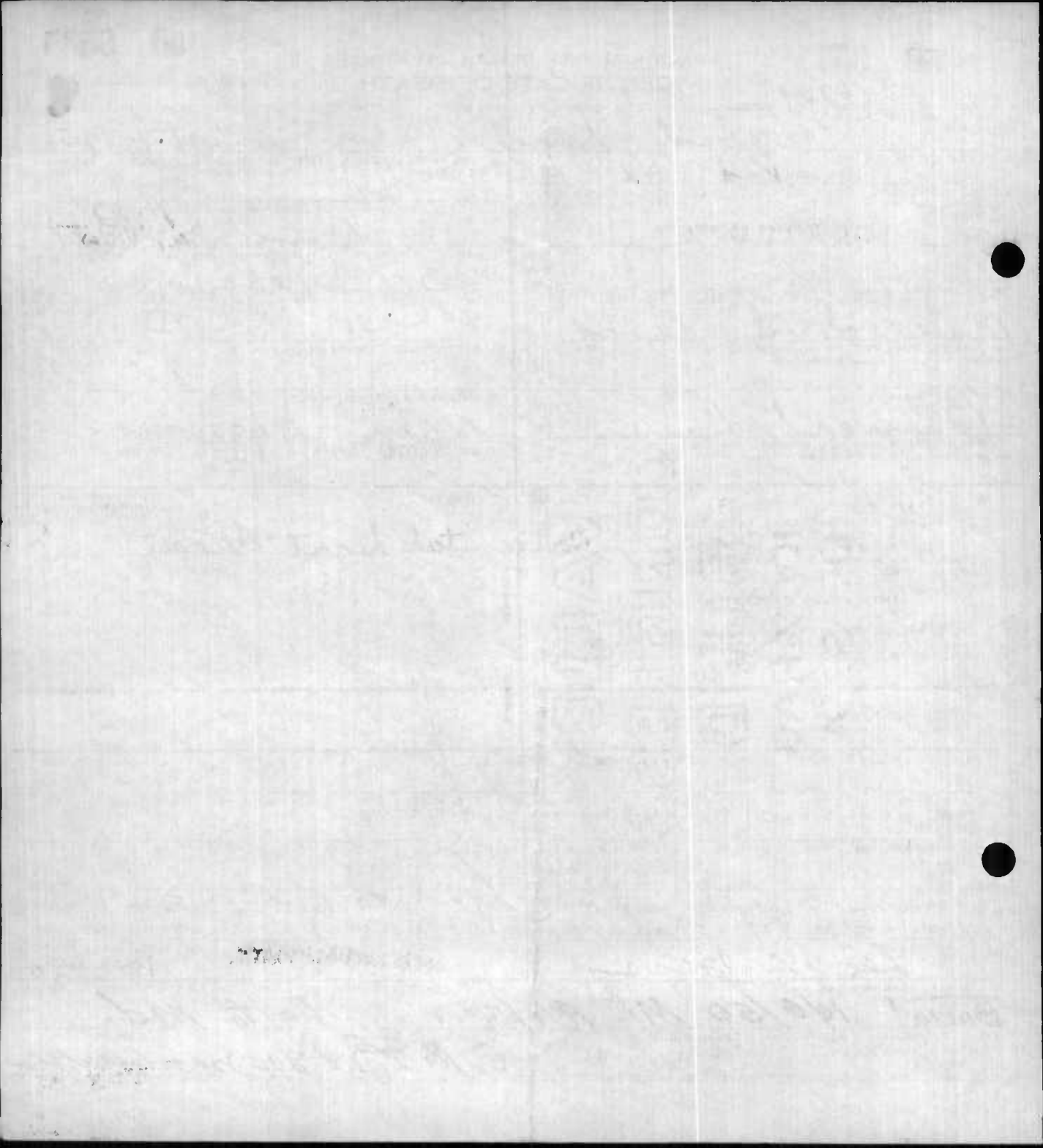
19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 9-29-, 1950 to 10-4-, 1950, that I last saw the deceased alive on 10-4-, 1950, and that death occurred at 2:24 P. m., from the causes and on the date stated above.

23A. SIGNATURE <u>Lee W. Bass</u> M. D.	23B. ADDRESS <u>JONES HOPKINS HOSPITAL</u>	23C. DATE SIGNED <u>10-4-50</u>
--	---	------------------------------------

24A. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10/6/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
---	-----------------------------	---	--

DATE RECEIVED BY LOCAL REGISTRAR <u>GT-51950</u>	REGISTRAR'S SIGNATURE <u>C. R. Law</u>	25. FUNERAL DIRECTOR <u>802 Madison Ave</u>	ADDRESS
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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **8536**

BIRTH NO

1. NAME OF DECEASED  
(Type or Print)

**Milton E. Powell**

2. DATE  
OF  
DEATH

**Oct. 4, 1950**

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE

b. COUNTY

c. CITY OR TOWN

d. STREET ADDRESS (If rural, give location)

Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months: Days  
If Under 24 Hours Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**Mrs. Frances M. Powell - 623 W. North**

18. **420.1**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

**Coronary Occlusion**

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Inspection** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23a. SIGNATURE

**Wm. H. Kammer, Jr.**

M.D.

23b. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23c. DATE SIGNED **Oct. 4, 1950**

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

**Burial**

**10/8/50**

**Edge hill**

**MANCOK, Va.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

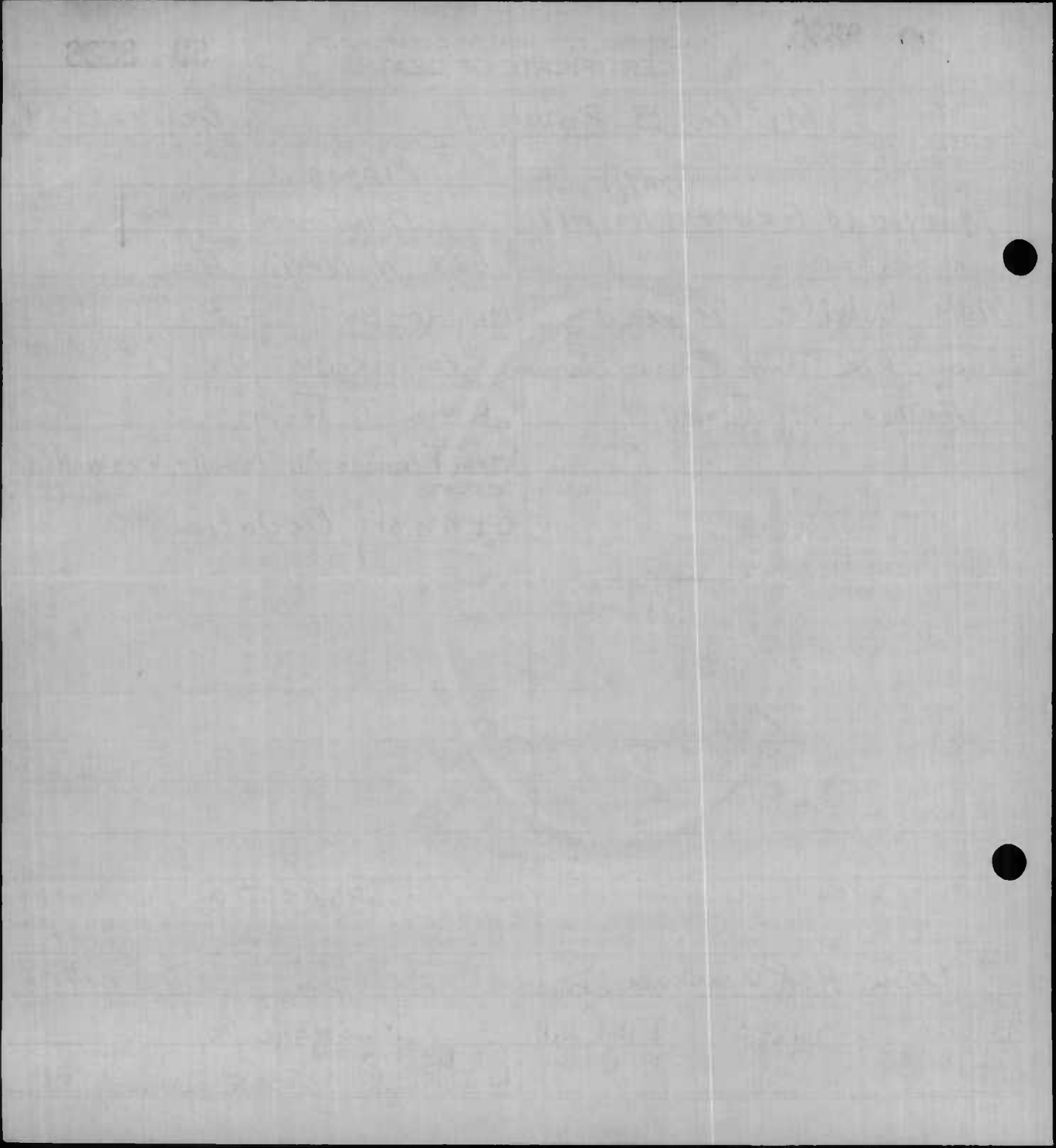
ADDRESS

**OCT - 5133**

**10/8/50**

**H. J. Ruck**

**5305 Hartford Rd**



H500  
50 8537BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 8537

BIRTH NO. *NR*1. NAME OF DECEASED  
(Type or Print)*David M. Hahn*2. DATE  
OF  
DEATH*October 5, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION*JONES HOPKINS HOSPITAL*4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE *MD* B. COUNTY *Frederick*C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Frederick 6011*D. STREET ADDRESS (If rural, give location)  
*136 E. South St*

E. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday) If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Joseph Hahn*

14. MOTHER'S MAIDEN NAME

*Mary Elizabeth*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*JONES HOPKINS HOSPITAL*18. *754.4*

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)(A) *Coronary failure*

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *congenital heart disease*

DUE TO

(C)

CERTIFICATION APPROVED BY

*Stanley K. Denecker*II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from *Oct 5, 1950*, to *Oct 5, 1950*, that I last saw the deceased alive on *Oct 5, 1950*, and that death occurred at *8:30 PM*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. O.

*JONES HOPKINS HOSPITAL**10/5/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

*Med. Ex Case To be approved 1572*

1925 02

1925 02

1

2

3

4

5

6



653 8538

8538

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>John Greenwood Jr</i>			2. DATE OF DEATH <i>Oct 4-1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>22-02</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>403 W Pratt St.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
c. Length of stay in Baltimore <i>40 yrs</i>			D. STREET ADDRESS (If rural, give location) <i>403 W Pratt St.</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>7 1895</i>	9. AGE (In years last birthday) <i>55</i>	10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Contractor</i>	11. BIRTHPLACE (State or foreign country) <i>Carroll County</i>		12. CITIZEN OF WHAT COUNTRY? <i>yes</i>
13. FATHER'S NAME <i>John Greenwood</i>			14. MOTHER'S MAIDEN NAME <i>?</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>?</i>	17. INFORMANT ADDRESS <i>Clara Greenwood 403 W Pratt St</i>		

MEDICAL CERTIFICATION

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH <i>Acute coronary occlusion</i>  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(A) <i>Acute coronary occlusion</i> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>
		(B) <i>Coronary artery atherosclerosis</i> DUE TO	<i>3-5 yr</i>
		(C) _____	
19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *1948*, 19\_\_, to *10-4-50*, 19\_\_, that I last saw the deceased alive on *8-3-50*, 19\_\_, and that death occurred at *230 P.M.*, from the causes and on the date stated above.

23A. SIGNATURE *[Signature]* M. D. 23B. ADDRESS *642 W. N. St.* 23C. DATE SIGNED *10-5-50*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 24B. DATE *Oct 8-1950* 24C. NAME OF CEMETERY OR CREMATORY *Prospect Cem.* 24D. LOCATION (City, town, or county) (State) *Frederick County Md*

DATE RECEIVED BY LOCAL REGISTRAR *OCT-6-1950* REGISTRAR'S SIGNATURE *[Signature]* 25. FUNERAL DIRECTOR *Joseph Kasenokas Jr.* ADDRESS *602 W. Wash*

1891-1892  
The following is a list of the  
names of the persons who  
were present at the  
meeting of the  
Board of Directors  
of the  
City of  
New York  
on the  
10th day of  
January  
1892.

Attest  
The City Clerk  
of the City of New York  
this 10th day of January  
1892.

630

N M 141329

50

8539

## BALTIMORE CITY HEALTH DEPARTMENT

50

8539

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Nancy Ward

2. DATE  
OF  
DEATH

September 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR INSTITUTION location)Baltimore City Hospitals  
4940 Eastern Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

11-03

D. STREET ADDRESS (If rural, give location)

717 Druidhill Ave.

Length of stay in Baltimore

19 years

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

?

9. AGE (In years  
last birthday)

68

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Records B.C.H. 4940 Eastern Ave.

18. 601X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHMore than  
one monthDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pyelonephritis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

(B) Bilateral Hydronephrosis

More than  
one monthII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY

DR. C. J. LUBINSKI

per: [Signature]

CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 9-4, 19 50, to 9-4, 19 50, that I last saw the  
deceased alive on 9-4, 19 50 and that death occurred at 2:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

[Signature]

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

9-7-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

[Signature]

25. F. N. E. A. DIRECTOR

Commissioner of Health

ADDRESS

OCT 6 1950

TO BE APPROVED BY MEDICAL EXAMINER

133a

MEDICAL CERTIFICATION

DEPARTMENT OF AGRICULTURE

UNITED STATES GOVERNMENT

WASHINGTON, D. C.

1917

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Israel Lipman

2. DATE  
OF  
DEATH

October 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

3231 Powhatan Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

City Baltimore

D. STREET ADDRESS (If rural, give location)

3231 Pohatan Ave

c. Length of stay in Baltimore

44 Yrs

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Dec. 23, 1896

9. AGE (In years  
last birthday)

53

If Under 1 Year  
Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman Whole Grocer & Foods

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Louis Lipman

14. MOTHER'S MAIDEN NAME

Sarah Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

215-10-9931

17. INFORMANT

ADDRESS

Minnie Weinstein 2816 Military Rd N. W.

Washington D. C.

18. 157X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

July 13, 1950

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Carcinoma of Pancreas

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Metastases to Liver

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

Aug 2, 1950

19B. MAJOR FINDINGS OF OPERATION

Carcinoma Pancreas, metastases to liver

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 13, 1950, to Oct 5, 1950, that I last saw the deceased alive on Oct 5, 1950, and that death occurred at 5 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Leonard Wallenstein

23B. ADDRESS

848 W 36th St

23C. DATE SIGNED

Oct 5, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct 6, 1950

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Rosedale Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

OCT - 6 1950

REGISTRAR'S SIGNATURE

Washington Hallmark, Jr.

25. FUNERAL DIRECTOR

Sol Furman & Bus W North ave

ADDRESS 1126

MEDICAL CERTIFICATION

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
IN SENATE

REPORT OF THE COMMISSIONER OF THE LAND OFFICE  
ON THE LANDS BELONGING TO THE STATE

ALBANY:

1887.

PRINTED BY THE STATE PRINTING OFFICE.

1887.

ALBANY:

1887.

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1887.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**SALLIE LOWENTHAL**

2. DATE  
OF  
DEATH

**Oct. 4<sup>th</sup> 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland **2210 Park Ave**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

**2210 Park Ave**

E. Length of stay in Baltimore

**lifetime**

Yrs.  
Mos.  
Days

5. SEX

**Female**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

**WIDOWED**

8. DATE OF BIRTH

**Feb. 28, 1860**

9. AGE (in years  
last birthday)

**90**

If Under 1 Year  
Months: Days

**7 6**

If Under 24 Hours  
Hours: Min.

**13-01**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Baltic Stern Baltic Rd.**

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

**Jacob Rubin**

14. MOTHER'S MAIDEN NAME

**Bettie Stern**

15. WAS DECEASED MEMBER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**Jacob Lowenthal 2210 Park Ave**

18. **420.1**

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

**Coronary Thrombosis**

**20 days**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

**acute virus bronchitis  
arteriosclerosis**

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **Sept 29**, 1950, to **Oct. 4**, 1950, that I last saw the deceased alive on **Oct 3**, 1950, and that death occurred at **5:45 P.m.**, from the causes and on the date stated above.

23A. SIGNATURE

**Miriam Fried**

M. D.

23B. ADDRESS

**# 316 Madison Ave Bldg**

23C. DATE SIGNED

**Oct 5/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

**Oct 6/50**

24C. NAME OF CEMETERY OR CREMATORY

**Hebrew Cemetery**

24D. LOCATION (City, town, or county) (State)

**Baltimore**

DATE RECEIVED BY  
LOCAL REGISTRAR

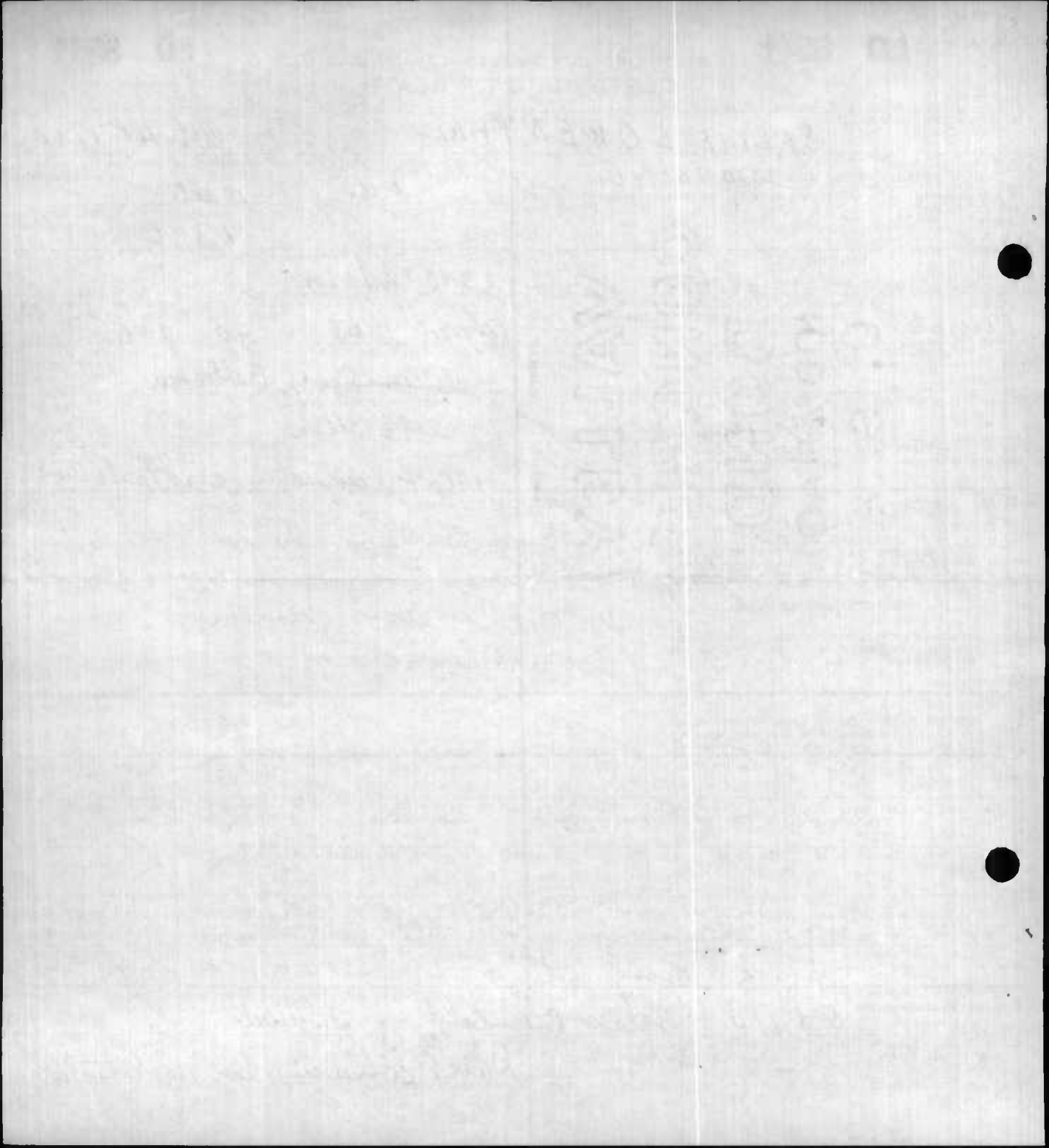
REGISTRAR'S SIGNATURE

**Hebrew Cemetery**

25. FUNERAL DIRECTOR

ADDRESS

**David Lowenthal 1402 Eastern Ave**



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**William Harmanus Fisher Jr**

2. DATE  
OF  
DEATH

**October 5, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

**1616 N. Calvert St.**

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

**Maryland**

C. CITY OR TOWN

**Baltimore**

(If outside corporate limits, write RURAL and give township)

**12-05**

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

**1616 North Calvert Street**

c. Length of stay in Baltimore

**64 yrs 11 mos 25d.**

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

**1616 North Calvert Street**

5. SEX

**Male**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**Married.**

8. DATE OF BIRTH

**September 11, 1885**

9. AGE (in years last birthday)

**64 yrs**

If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Accountant**

10B. KIND OF BUSINESS OR INDUSTRY

**Welding Equipment**

11. BIRTHPLACE (State or foreign country)

**Maryland**

12. CITIZEN OF WHAT COUNTRY?  
**U. S. A.**

13. FATHER'S NAME

**William Harmanus Fisher Sr.**

14. MOTHER'S MAIDEN NAME

**Edith Ridgely**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**No**

16. SOCIAL SECURITY NO.

17. INFORMANT

**William H. Fisher III**

ADDRESS

**1616 N. Calvert St.**

18. **163X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Carcinoma of Lungs**

**three Months or more**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

**Diabetes**

**ten Years**

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **October 3, 1950** to **October 5, 1950**, that I last saw the deceased alive on **October 5, 1950**, and that death occurred at **4<sup>00</sup> A** m., from the causes and on the date stated above.

23A. SIGNATURE

**Henry Beatty Wilson**

M. D.

23B. ADDRESS

**1214 Eutaw Place and 3 W. Biddle St. Balto.**

23C. DATE SIGNED

**10-5-50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

**10/7/50**

24C. NAME OF CEMETERY OR CREMATORY

**PARKWOOD**

24D. LOCATION (City, town, or county)

**BALTO, Md**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**for William**

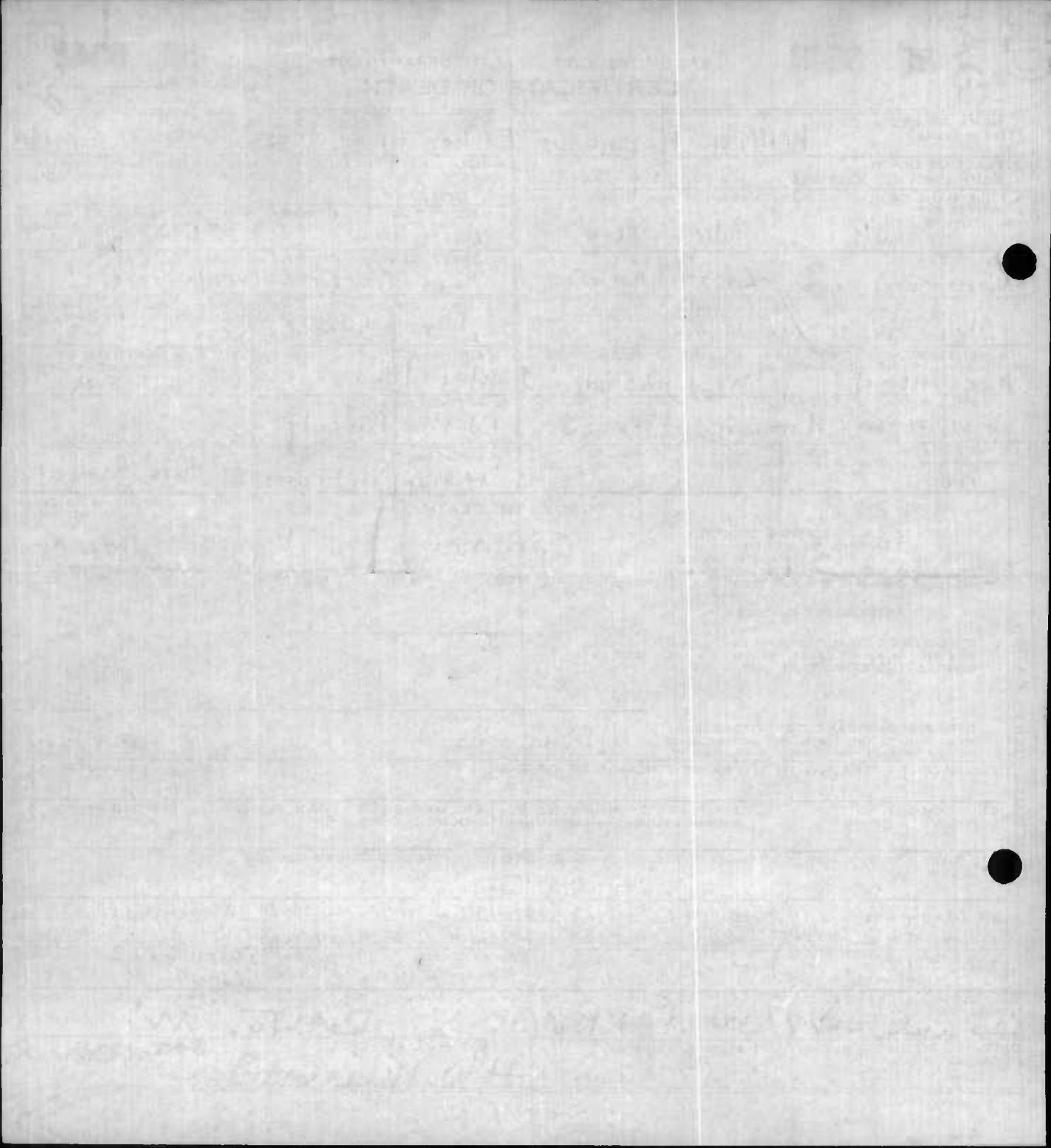
25. FUNERAL DIRECTOR

**H. W. Mearns**

ADDRESS

**805 N. Calvert**

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*MRS. STELLA Wisniewski*

2. DATE  
OF  
DEATH

*Oct 5 1950*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

*Maryland General*

4. USUAL RESIDENCE Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

*Maryland*  
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore 1-02*

c. Length of stay in Baltimore

*67 years*

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

*502 S. Potomac Street*

5. SEX

*F*

6. COLOR OR RACE

*W*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Widow*

8. DATE OF BIRTH

*March 19 1881*

9. AGE (In years last birthday)

*69*

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Poland*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*John Rychnowski*

14. MOTHER'S MAIDEN NAME

*Lena Babrowska*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS *502*

*Josephine Lambrecht S. Potomac*

18. *587.0*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*Acute Pneumonia*

INTERVAL BETWEEN ONSET AND DEATH

*4 days*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

*Uremia*

*1 day*

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

*none*

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *9/29/*, 19*50*, to *10/5/*, 19*50*, that I last saw the deceased alive on *10/5/*, 19*50*, and that death occurred at *7:30 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

*Anthony C. Kerone M.D.*

*Maryland Jan 10/1950*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

*Burial*

*Oct 9 1950*

*St Stanislaus*

*Baltimore*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

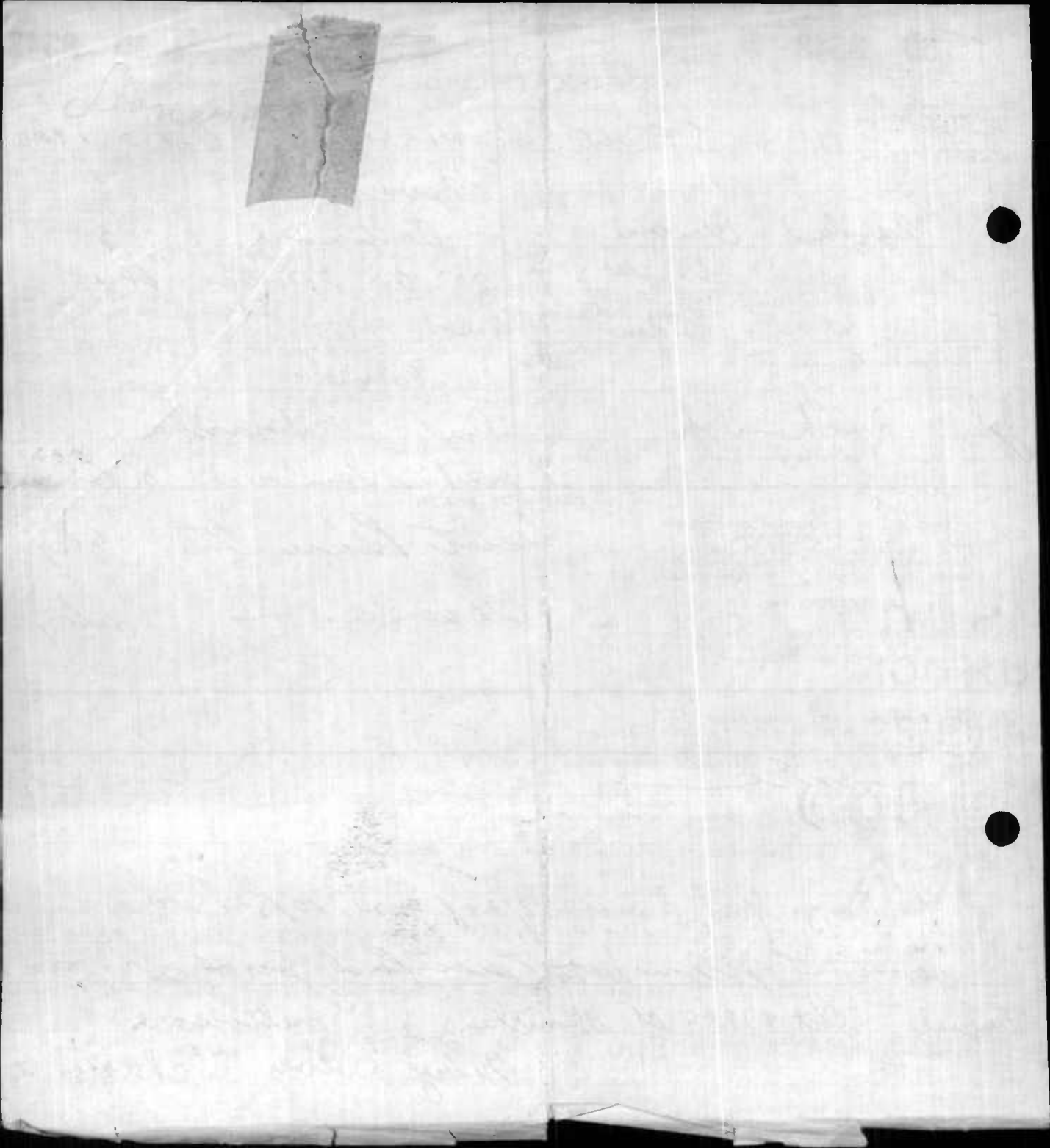
25. FUNERAL DIRECTOR

ADDRESS

*OCT - 6 1950*

*Anthony C. Kerone M.D.*

*Mary Weby 401 Chester St*





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Iva Myra Wyble*

2. DATE  
OF  
DEATH

*Oct 3 50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*Balto*

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

*6612 Fair Ave*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *Md* B. COUNTY \_\_\_\_\_

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)  
*Balto 26-05*

D. STREET ADDRESS (If rural, give location)  
*6612 Fair Ave*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*Female*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*divorced*

8. DATE OF BIRTH

*July 2 1878*

9. AGE (In years  
last birthday)

*72*

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

*at home*

11. BIRTHPLACE (State or foreign country)

*Pa*

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

*Samuel Knepshield*

14. MOTHER'S MAIDEN NAME

*Agnes Ashbaugh*

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT ADDRESS  
*Robert W. Wyble 6612 Fair Ave*

18. *442X*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *A-D C.V.-R. Disease*  
DUE TO

*5 yrs*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_  
DUE TO  
(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

*Hypertrophic Arteriosclerosis*

*10 yrs*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *May 45*, 19*45*, to *Oct 3*, 19*50*, that I last saw the deceased alive on *Oct 1*, 19*50*, and that death occurred at *4:10 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*J. J. Davis M.D.*

23B. ADDRESS

*6800 Monmouth Rd. - Dundalk, Md.*

23C. DATE SIGNED

*10/5/50*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

*Oct 6/50*

24C. NAME OF CEMETERY OR CREMATORY

*Meadow Ridge*

24D. LOCATION (City, town, or county)

*Howard Co*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

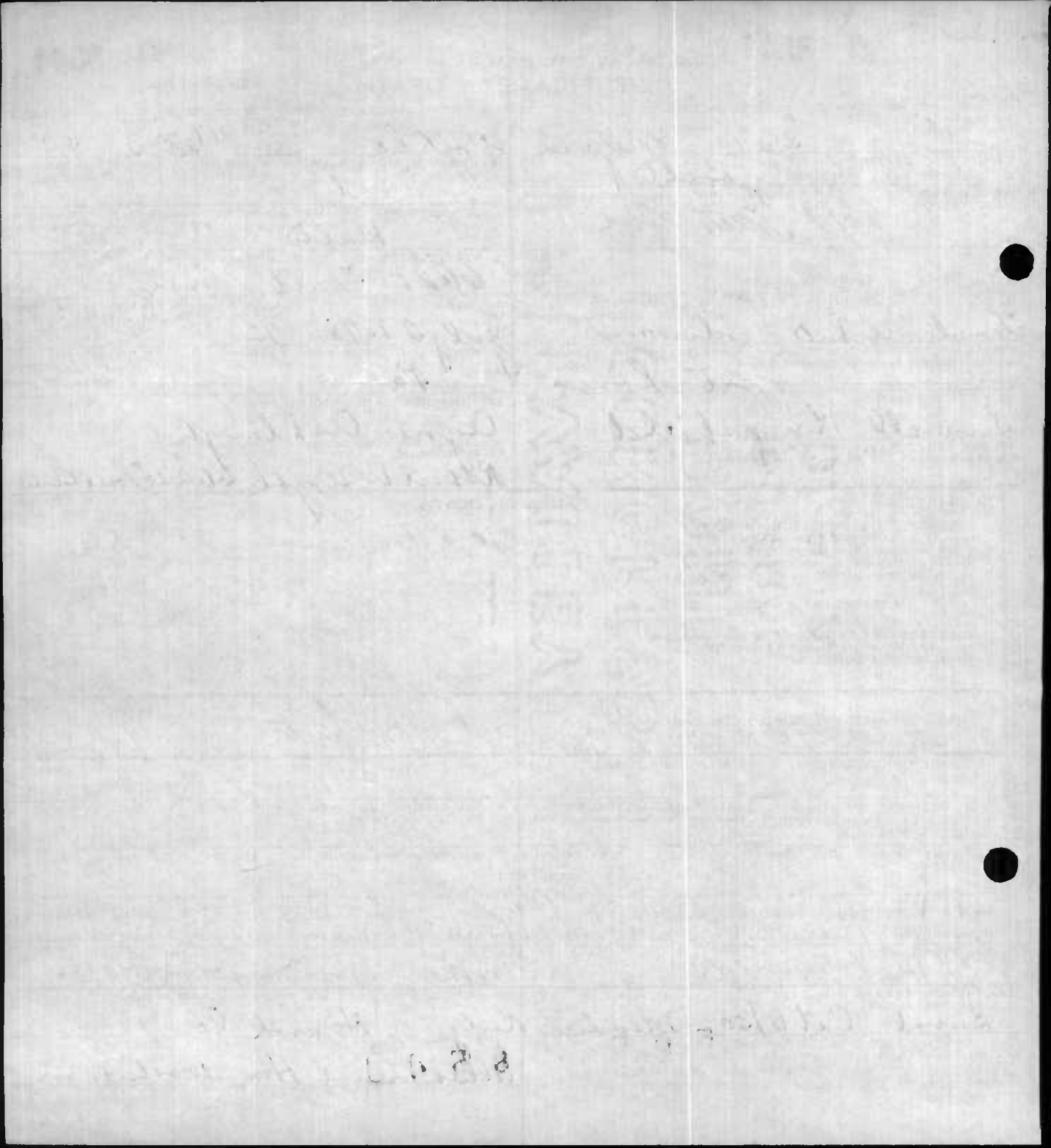
*Thurston Williams, Jr.*

25. FUNERAL DIRECTOR

ADDRESS

*Edith Land Home 2004 Calver*

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

PHILLIP GOLDSBOROUGH GOOTEE

2. DATE  
OF  
DEATH

OCT 6, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street address or location)

UNION MEMORIAL HOSPITAL

Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

JUNE 18, 1897

9. AGE (in years  
last birthday)

53

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

FARMER

10b. KIND OF BUSINESS OR  
INDUSTRY

FARMING

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

ALBERT F GOOTEE

14. MOTHER'S MAIDEN NAME

CLARA HARPER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 223X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

BRAIN TUMOR (MENINGIOMA)

12 hrs.  
4 yrs. (?)

DUE TO

Cerebral Hemorrhage

ANTECEDENT CAUSES

(B)

operation for brain tumor

4 yrs.

DUE TO

meningioma

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

10-5-50

19b. MAJOR FINDINGS OF OPERATION

MENINGIOMA

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

OF INJURY

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from OCT 4, 1950, to OCT 6, 1950, that I last saw the  
deceased alive on OCT 6, 1950, and that death occurred at 12:05 A.M., from the causes and on the date stated above.

23a. SIGNATURE

Robert B. Caraway Jr.

M. O.

23b. ADDRESS

Union Memorial Hosp. 10-6-50

23c. DATE SIGNED

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24b. DATE

10-8-50

24c. NAME OF CEMETERY OR CREMATORY

Wendover Mem P.

24d. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

OCT - 6 1950

25. FUNERAL DIRECTOR

ADDRESS

300 1/2 bushels of corn 12-8-00 2000  
100 1/2 bushels of corn 12-8-00 2000  
100 1/2 bushels of corn 12-8-00 2000  
100 1/2 bushels of corn 12-8-00 2000

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**JAMES P. BOTTORFF**

2. DATE  
OF  
DEATH

**10/5/50**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**SINAI HOSPITAL**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

**INDIANA**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**CHARLESTOWN**

D. STREET ADDRESS (If rural, give location)

---

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

**M**

6. COLOR OR RACE

**W**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**MARRIED**

8. DATE OF BIRTH

**Aug. 14, 1902**

9. AGE (In years last birthday)

**48**

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Druggist**

10B. KIND OF BUSINESS OR INDUSTRY

**Own Drug Busi.**

11. BIRTHPLACE (State or foreign country)

**Indiana**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Charles M. Bottorff**

14. MOTHER'S MAIDEN NAME

**Katherine Piatt**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

---

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
**Dr. David C. Bottorff - Charlestown, Ind.**

18. **E 894.6**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **ACUTE YELLOW ATROPHY 2-3d.**  
**OF LIVER**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **CARBON TETRACHLORIDE 2 1/2 wk.**  
**FUME INHALATION**

CERTIFICATION APPROVED BY

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) **ANURIA 1 1/2 wk.**

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

CHIEF OR ASST. MEDICAL EXAMINER

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

**ACCIDENT**

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

**PHARMACY**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

**CHARLESTOWN, INDIANA**

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

**SEPT. 17, 1950 ? m.**

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

**while cleaning stains**  
**ACCIDENTAL INHALATION**

22. I hereby certify that I attended the deceased from **9/22**, 19**50**, to **10/5**, 19**50**, that I last saw the deceased alive on **10/5**, 19**50**, and that death occurred at **4:00** m. from the causes and on the date stated above.

23A. SIGNATURE

**Malcolm E. Fisher**

23B. ADDRESS

**Sinai Hospital**

23C. DATE SIGNED

**10/5/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Removal**

24B. DATE

**10/6/50**

24C. NAME OF CEMETERY OR CREMATORY

**Charlestown**

24D. LOCATION (City, town, or county)

**Charlestown, Ind.**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

**OCT-6-1950**

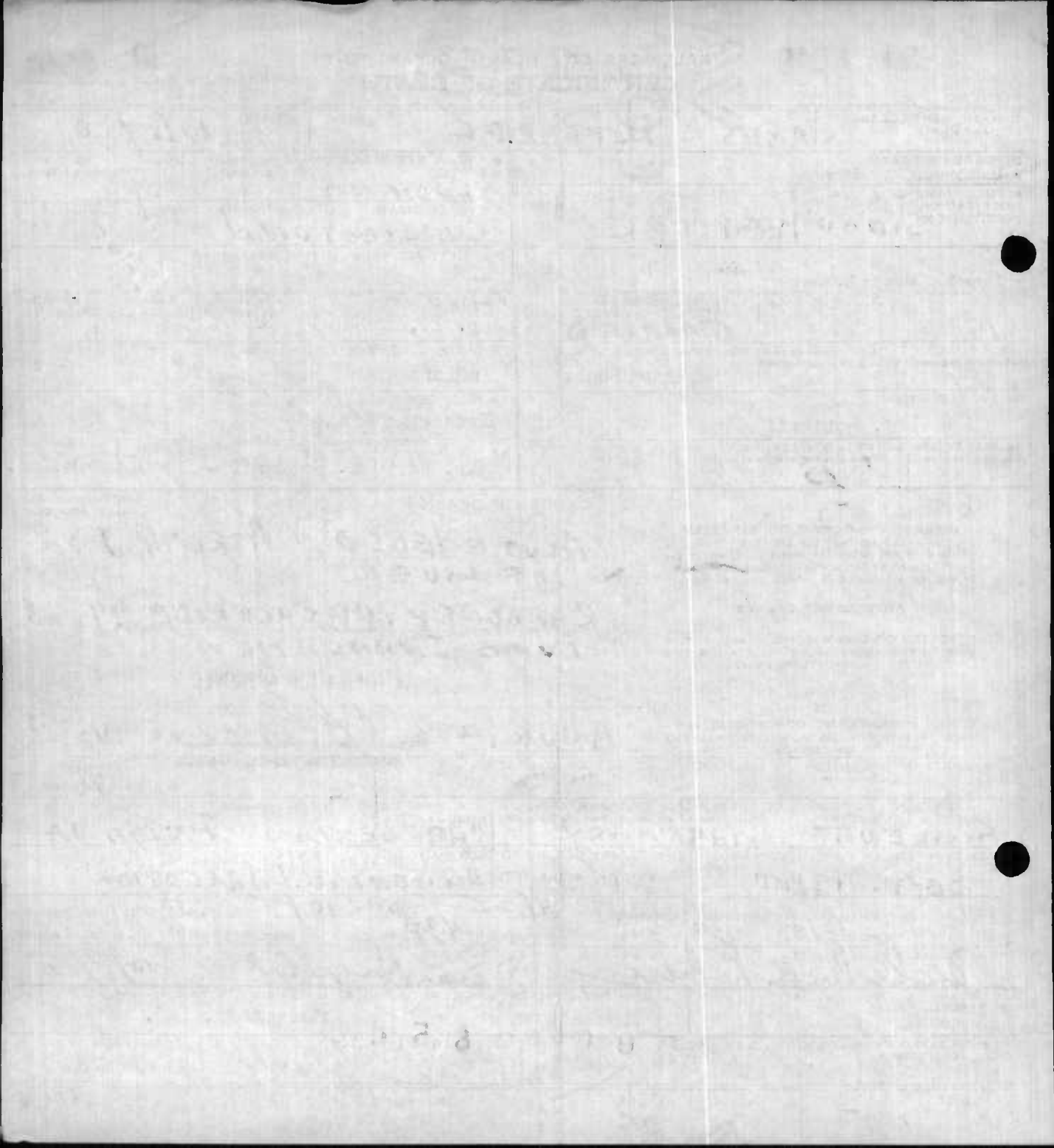
REGISTRAR'S SIGNATURE

**Malcolm E. Fisher**

25. FUNERAL DIRECTOR

**Wm. Fickner & Sons - Toledo**

ADDRESS





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*William H. Hill*

2. DATE  
OF  
DEATH

*Oct 4-1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *1342 W. Mosher St*

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *Balto* B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Balto. 16-02*

C. Length of stay in Baltimore *60 yrs*

5. SEX *Male* 6. COLOR OR RACE *Colored* 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *Widowed*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Waiter* 10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME *Wm H. Hill*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

D. STREET ADDRESS (If rural, give location) *1342 W. Mosher St*

8. DATE OF BIRTH *June 14, 1870* 9. AGE (In years last birthday) *80 yrs*

11. BIRTHPLACE (State or foreign country) *Chesterton, Ind* 12. CITIZEN OF WHAT COUNTRY? *U.S.A*

14. MOTHER'S MAIDEN NAME *Nancy Johnson*

17. INFORMANT *Alberta Dorsey* ADDRESS *1342 W. Mosher St*

18. *443X* CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Congestive heart failure* DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Hypertensive Cardio-Vascular Disease & Atrial Fibrillation* DUE TO

(C) *Found dead on floor of kitchen*

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION *0* 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐ 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *March 17, 1947* to *Oct 4, 1950*, that I last saw the deceased alive on *July 7, 1948*, and that death occurred at *1:30 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE *Geo. McDonald* 23B. ADDRESS *844 N Carey* 23C. DATE SIGNED *10/6/50*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 24B. DATE *Oct 9-50* 24C. NAME OF CEMETERY OR CREMATORY *Mt Auburn* 24D. LOCATION (City, town, or county) (State) *Balto*

DATE RECEIVED BY LOCAL REGISTRAR *OCT-6-1950* REGISTRAR'S SIGNATURE *W. H. Williams* 25. FUNERAL DIRECTOR *James A. Hayes* ADDRESS *638 N. 9th St*

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>MARY Marie MURPHY</b>			2. DATE OF DEATH <b>October 3, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>14-03</b>		
D. STREET ADDRESS (If rural, give location) <b>1807 McCulloh Street</b>			E. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Dec 7</b>		9. AGE (In years last birthday) <b>55</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic work</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Bath Md</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>George Mcready</b>			14. MOTHER'S MAIDEN NAME <b>Mary Stewart</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>John Mcready 506 N. Decatur St</b>		

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive heart disease</b> (A) _____ DUE TO _____  ANTECEDENT CAUSES (B) _____ DUE TO _____ (C) _____  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., to or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>R. F. Fisher</b>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>10-4-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Oct 6 - 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>W. O. B. Md</b>	24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR <b>Oct 1 - 1950</b>		REGISTRAR'S SIGNATURE <b>W. O. B. Md</b>		
25. FUNERAL DIRECTOR		ADDRESS <b>1515 McCulloh St</b>		



5-530

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>John Smith</i>			2. DATE OF DEATH <i>Oct 4, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Med. Dept 2</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>JOHN HOPKINS HOSPITAL</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 16-01</i>		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <i>1004 N. Arlington Ave</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>1908</i>	9. AGE (In years last birthday) <i>42</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Rigger</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>SHIPYARD</i>		
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>			12. CITIZEN OF WHAT COUNTRY? <i>✓</i>		
13. FATHER'S NAME <i>John Smith</i>			14. MOTHER'S MAIDEN NAME <i>Matthe Townsend</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>JOHN HOPKINS HOSPITAL</i>			ADDRESS		

18. *023X*

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

*Congestive heart failure**1 week*

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

*Aortic regurgitation*

DUE TO

(C)

*Syphilitic aortitis**3**2*

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

*Uremia*19A. DATE OF OPERATION *0*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *9-30-*, 19*50* to *10-4-*, 19*50*, that I last saw the deceased alive on *10-4-*, 19*50* and that death occurred at *10:45* a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

*BURIAL**10-7-50**MT. AUBURN**BALTIMORE, 30.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

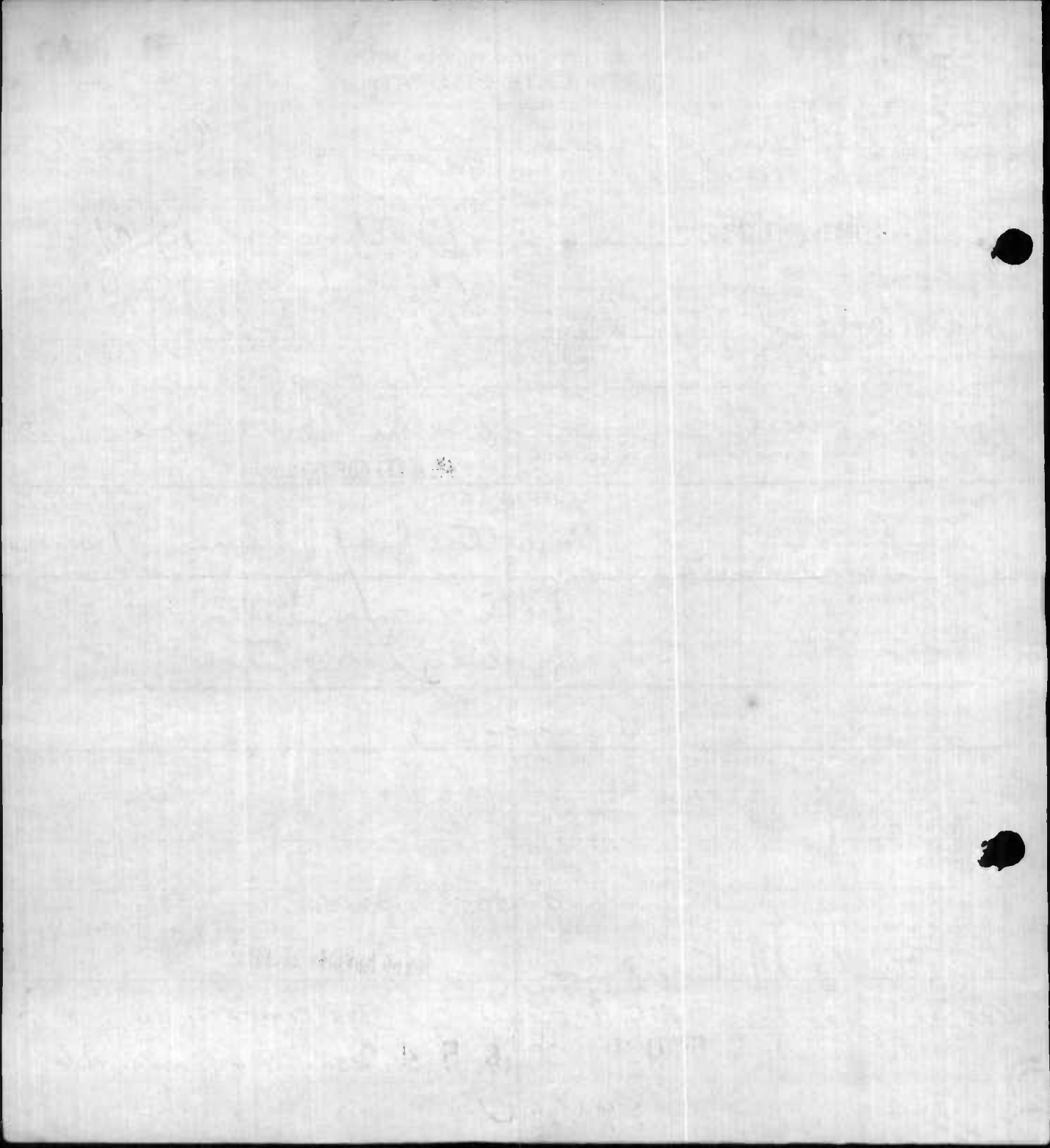
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MEDICAL CERTIFICATION



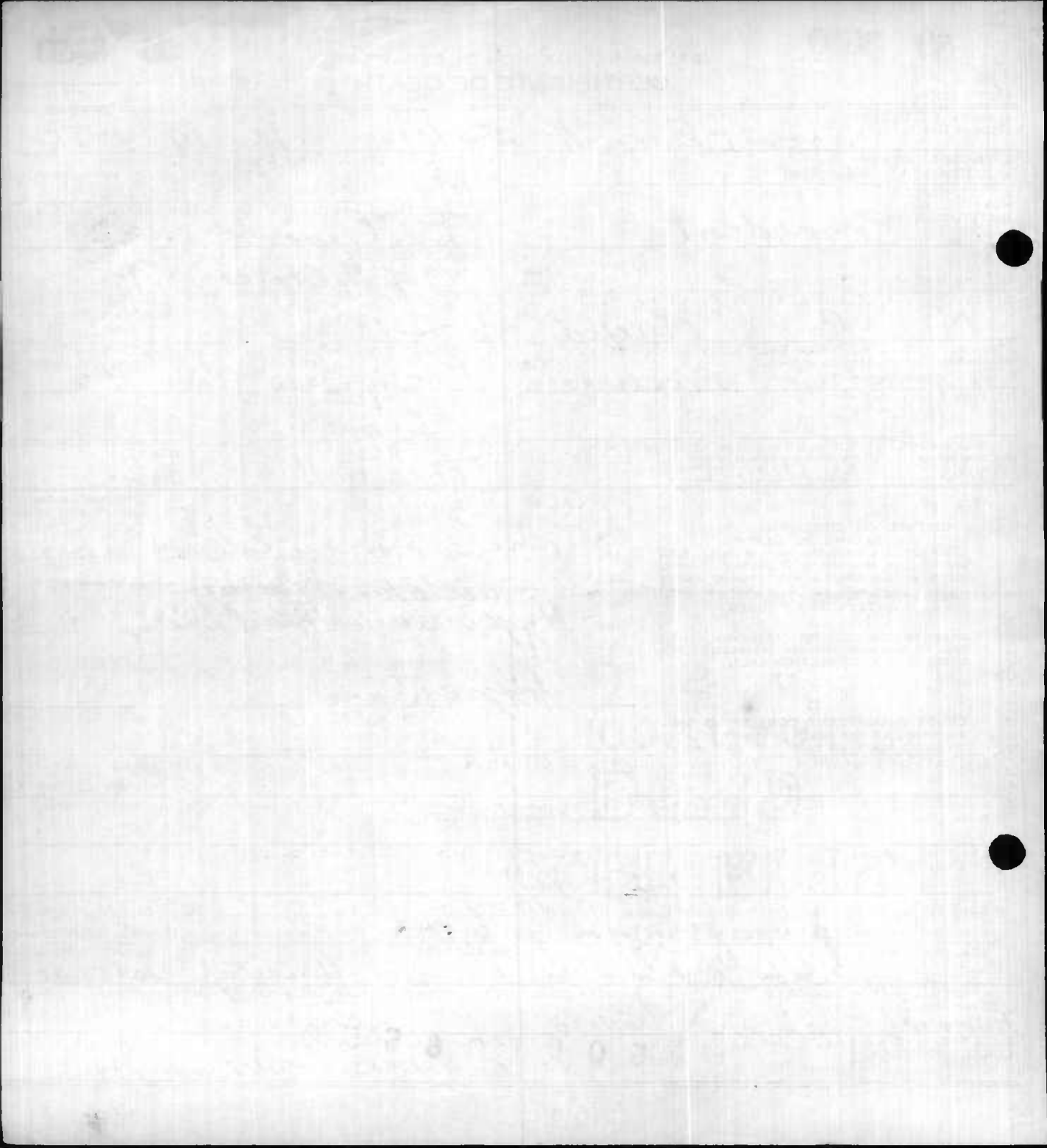


**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Robert Everett Bell</b>		2. DATE OF DEATH <b>10-4-50</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY _____	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 19-02</b>	
c. Length of stay in Baltimore		d. STREET ADDRESS (If rural, give location) <b>224 N. Stricker St.</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>11-13-1893</b>
9. AGE (In years, last birthday) <b>56</b>		10. Under 1 Year: Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paperhanger</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Freelance</b>	
11. BIRTHPLACE (State or foreign country) <b>Rocky Mount, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME _____		14. MOTHER'S MAIDEN NAME <b>Irma?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>World War I</b>	
17. INFORMANT <b>Rosa Bell</b>		ADDRESS <b>Same</b>	
18. <b>443x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Edema</b>		CAUSE OF DEATH (A) <b>Acute Heart Failure</b> (B) <b>Hypertensive Heart Disease</b> (C) <b>Hypertension</b>	
INTERVAL BETWEEN ONSET AND DEATH <b>2 hr 45 min</b>			
19. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>10-4-1950</b> , to <b>10-4-1950</b> , that I last saw the deceased alive on <b>10-4-1950</b> , and that death occurred at <b>4:16 P.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>E. C. Walden</b>		23b. ADDRESS <b>Provident Hospital</b>	
23c. DATE SIGNED <b>10/5/50</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>10-6-50</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>ROANOKE</b>		24d. LOCATION (City, town, or county) (State) <b>ROANOKE, VA.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT-6-1950</b>		REGISTRAR'S SIGNATURE <b>Wm. A. JACKSON</b>	
25. FUNERAL DIRECTOR <b>Wm. A. JACKSON</b>		ADDRESS <b>916 PENNA. AVE.</b>	



460  
50 8551

DUPLICATE COPY (ORIGINAL LOST)  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

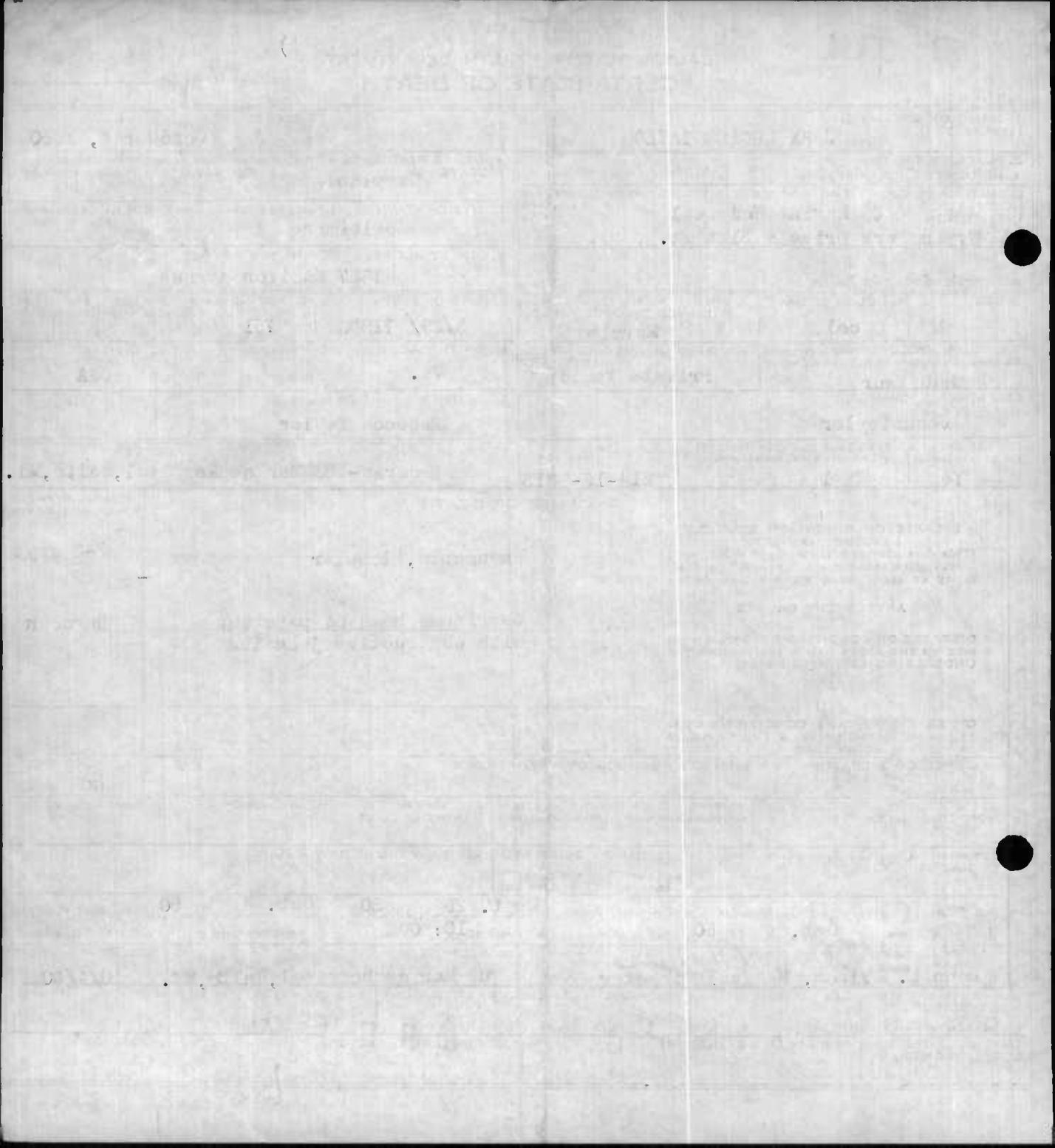
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>JOHN LUCIUS TAYLOR</b>		2. DATE OF DEATH <b>October 4, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>US Marine Hospital</b> <b>Wyman Park Drive &amp; 31st St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>14-03</b>	
c. Length of stay in Baltimore <b>?</b> Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>1827 Madison Avenue</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>col</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>5/29/ 11899</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		9. AGE (In years last birthday) <b>751</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
13. FATHER'S NAME <b>John Taylor</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-18-8813</b>	
14. MOTHER'S MAIDEN NAME <b>Rebecca Taylor</b>		17. INFORMANT ADDRESS <b>Records- US Marine Hospital, Balto, Md.</b>	

18. <b>157X</b> CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia, lobular</b>		<b>2-3 days</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Carcinoma head of pancreas with obstructive jaundice</b>		<b>Unknown</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>2</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>Sept. 29, 1950</b> to <b>Oct. 4, 1950</b> , that I last saw the deceased alive on <b>Oct. 4, 1950</b> , and that death occurred at <b>10:40 A.M.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>John L. Wilson, Medical Director</b>		23B. ADDRESS <b>US Marine Hospital, Balto, Md.</b>		23C. DATE SIGNED <b>10/4/50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <b>Oct 6, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Balto National</b>	24D. LOCATION (City, town, or county) (State) <b>Balto, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT - 6 1950</b>	REGISTRAR'S SIGNATURE <b>William Williams, Jr.</b>	25. FUNERAL DIRECTOR <b>Holland Funeral Home</b> <b>1631 W. mid Hill Ave.</b>		



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

DORA BERTIANSKY

2. DATE  
OF  
DEATH

10-5-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Md

13-04

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

4933 Edgemere Ave Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

D. STREET ADDRESS (If rural, give location)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year If Under 24 Hours  
Months: Days Hours: Min.

35

7308 Bryant Ave

56

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Female

White

married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Jacob

14. MOTHER'S MAIDEN NAME

Rebecca

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Morris Bertiansky - Same

18. 163x

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Carcinoma of Lung, left

12 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

None

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORKNOT WHILE  
AT WORK22. I hereby certify that I attended the deceased from 0429 1949, to 0431, 1950, that I last saw the  
deceased alive on 0404, 1950, and that death occurred at 5:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

3600 Park Heights Ave

0405, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Томпакон  
3600 Park Hy  
Mo 5776



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. 48-23651

1. NAME OF DECEASED  
(Type or Print)

**GEORGE WATSON**

2. DATE  
OF  
DEATH

**50 OCTOBER 50**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

**14 E. Hill St**

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

**14 E. Hill St**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

**14 E. Hill St Md.**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Balto. 22-01**

D. STREET ADDRESS (If rural, give location)

**14 E. Hill St**

c. Length of stay in Baltimore

**Life**

5. SEX

**MALE**

6. COLOR OR RACE

**white**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**single**

8. DATE OF BIRTH

**Oct. 1, 1948**

9. AGE (In years last birthday)

**2 yrs.**

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**infant**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Balto. Md.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Jesse Watson**

14. MOTHER'S MAIDEN NAME

**Shirley Wallner**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**no none**

16. SOCIAL SECURITY NO.

**none**

17. INFORMANT

ADDRESS

**Elizabeth Sawyer - 14 E. Hill St**

18. **754.4**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Focal endocardial fibro-elastosis left ventricle**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Acute laryngitis**

DUE TO

CERTIFICATION APPROVED BY

**R. F. Fisher**

M. D.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

CHIEF OR ASST. MEDICAL EXAMINER.

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **5 Oct 50**, 19**50**, to **5 Oct 50**, 19**50**, that I last saw the deceased alive on **5 Oct 50**, 19**50**, and that death occurred at **5 Oct 50**, from the causes and on the date stated above.

23A. SIGNATURE

**William V. Brown, Jr.**

M. D.

23B. ADDRESS

**Simi Hox.**

23C. DATE SIGNED

**5 Oct 50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**Oct. 7, 1950**

24C. NAME OF CEMETERY OR CREMATORY

**Woodlawn**

24D. LOCATION (City, town, or county) (State)

**Woodlawn Balto Md.**

DATE RECEIVED BY LOCAL REGISTRAR

**OCT - 6 1950**

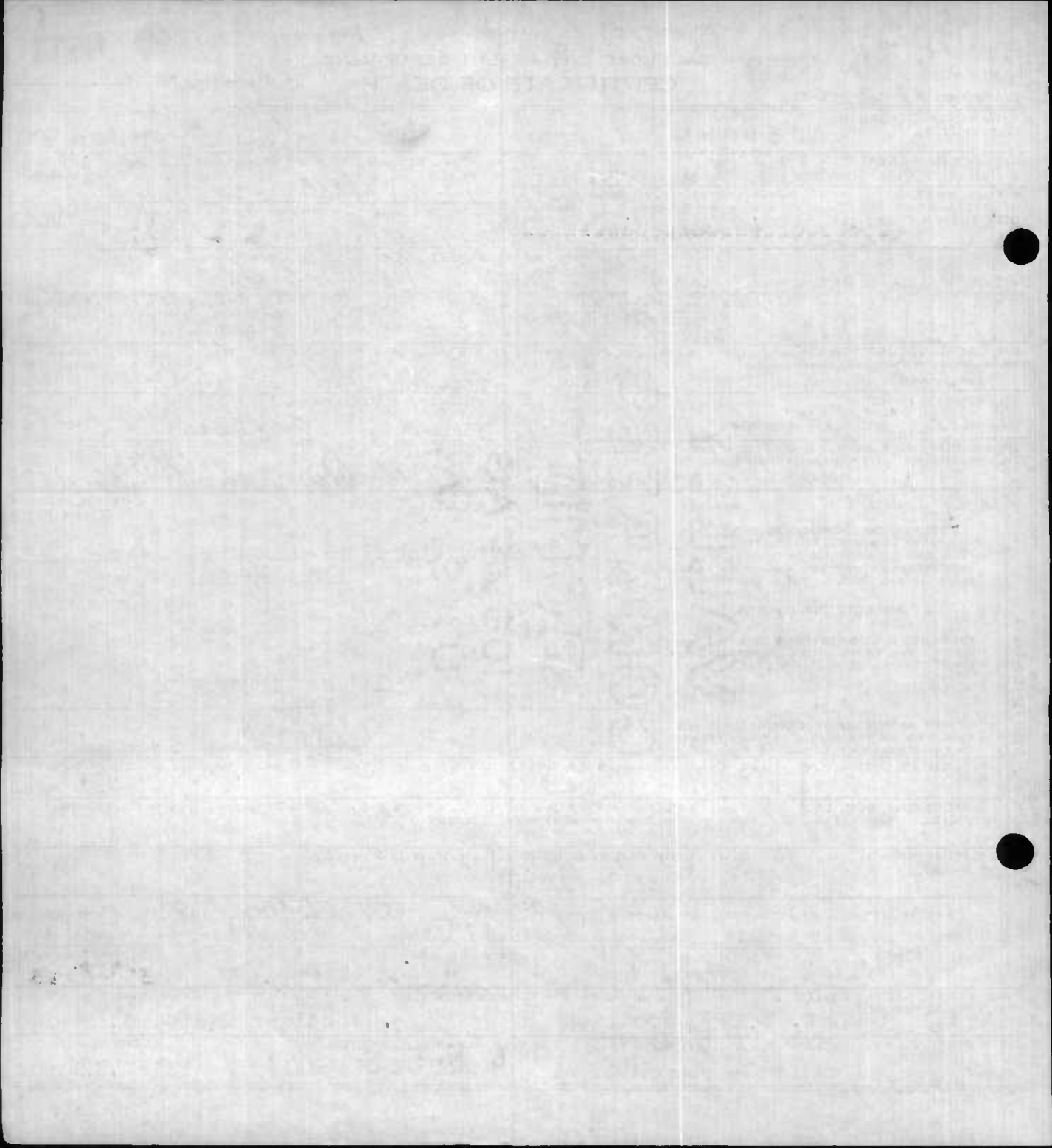
REGISTRAR'S SIGNATURE

**Washington Williams, Jr.**

25. FUNERAL DIRECTOR

ADDRESS

**KRAUSE FUNERAL HOME 1216S. Charles**



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

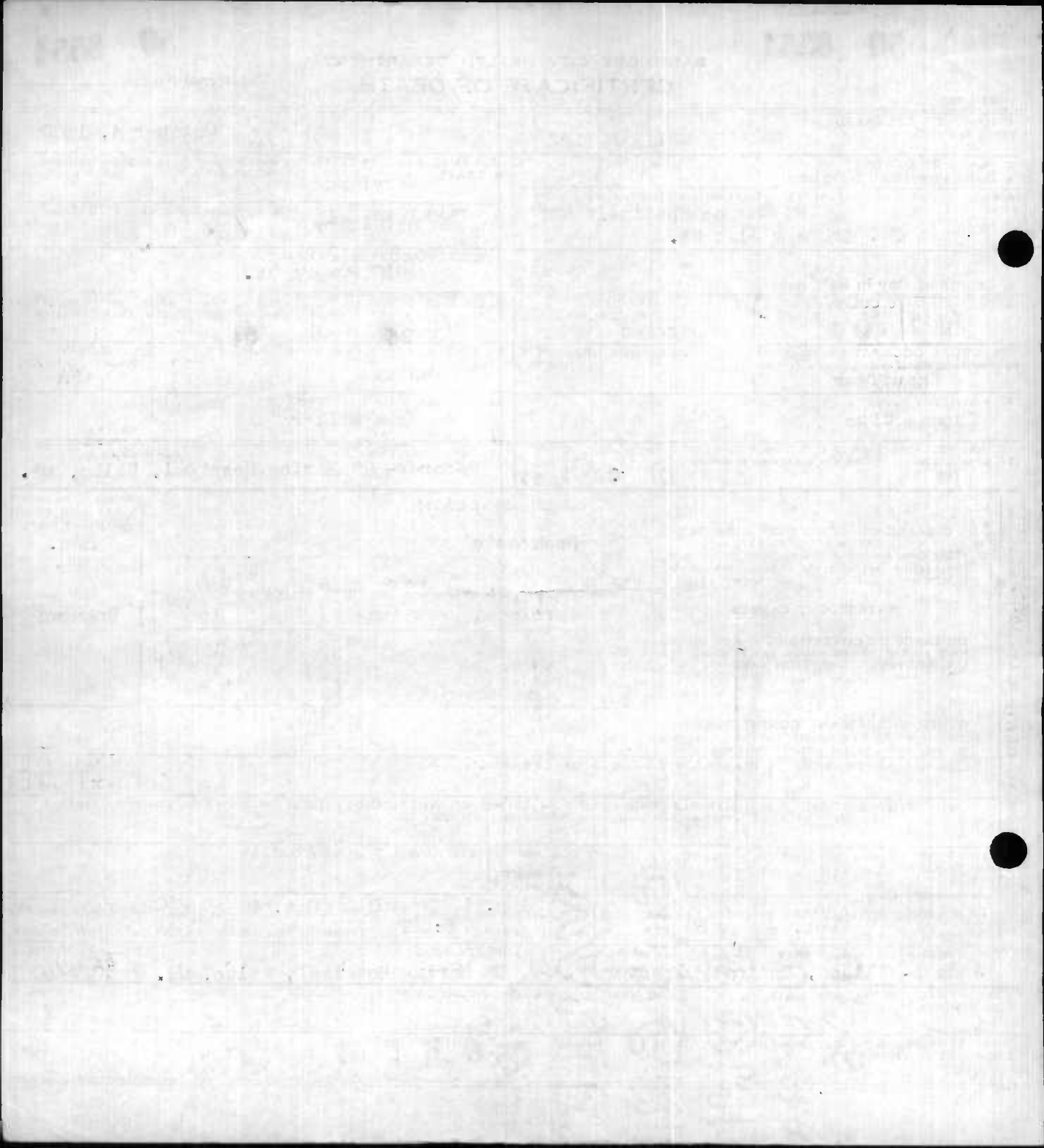
1. NAME OF DECEASED (Type or Print) <b>CHARLES WILLIAM HITE</b>				2. DATE OF DEATH <b>October 4, 1950</b>			
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>US Marine Hospital Wyman Pk. Drive &amp; 31st St.</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <span style="float:right">13-06</span>			
c. Length of stay in Baltimore <b>?</b> Yrs. _____ Mos. _____ Days _____				D. STREET ADDRESS (If rural, give location) <b>810 Powers St.</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>9/29/96</b>		9. AGE (In years last birthday) <b>54</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Hite</b>				14. MOTHER'S MAIDEN NAME <b>Augusta Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>213-05-7697</b>		17. INFORMANT ADDRESS <b>Records- US Marine Hospital, Balto, Md.</b>			

MEDICAL CERTIFICATION

18. <b>163X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Nephrosis</b> (A) DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH <b>More than 3 mos.</b>  <b>Unknown</b>
ANTECEDENT CAUSES <b>Carcinoma left lung</b> (B) DUE TO _____		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>2</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Aug. 1</b> , 19 <b>50</b> , to <b>Oct. 4</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>Oct. 4</b> , 19 <b>50</b> and that death occurred at <b>4:20P</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>John L. Wilson, Medical Director</b>		23B. ADDRESS <b>US Marine Hospital, Balto, Md.</b>		23C. DATE SIGNED <b>10/5/50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct 9, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balto. National</b>		24D. LOCATION (City, town, or county) (State) <b>Frederick Ave.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT - 61950</b>		REGISTRAR'S SIGNATURE <i>W. Williams</i>		25. FUNERAL DIRECTOR <i>Paul E. Schaefer</i>		ADDRESS <i>3615-17 Chestnut Ave.</i>	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

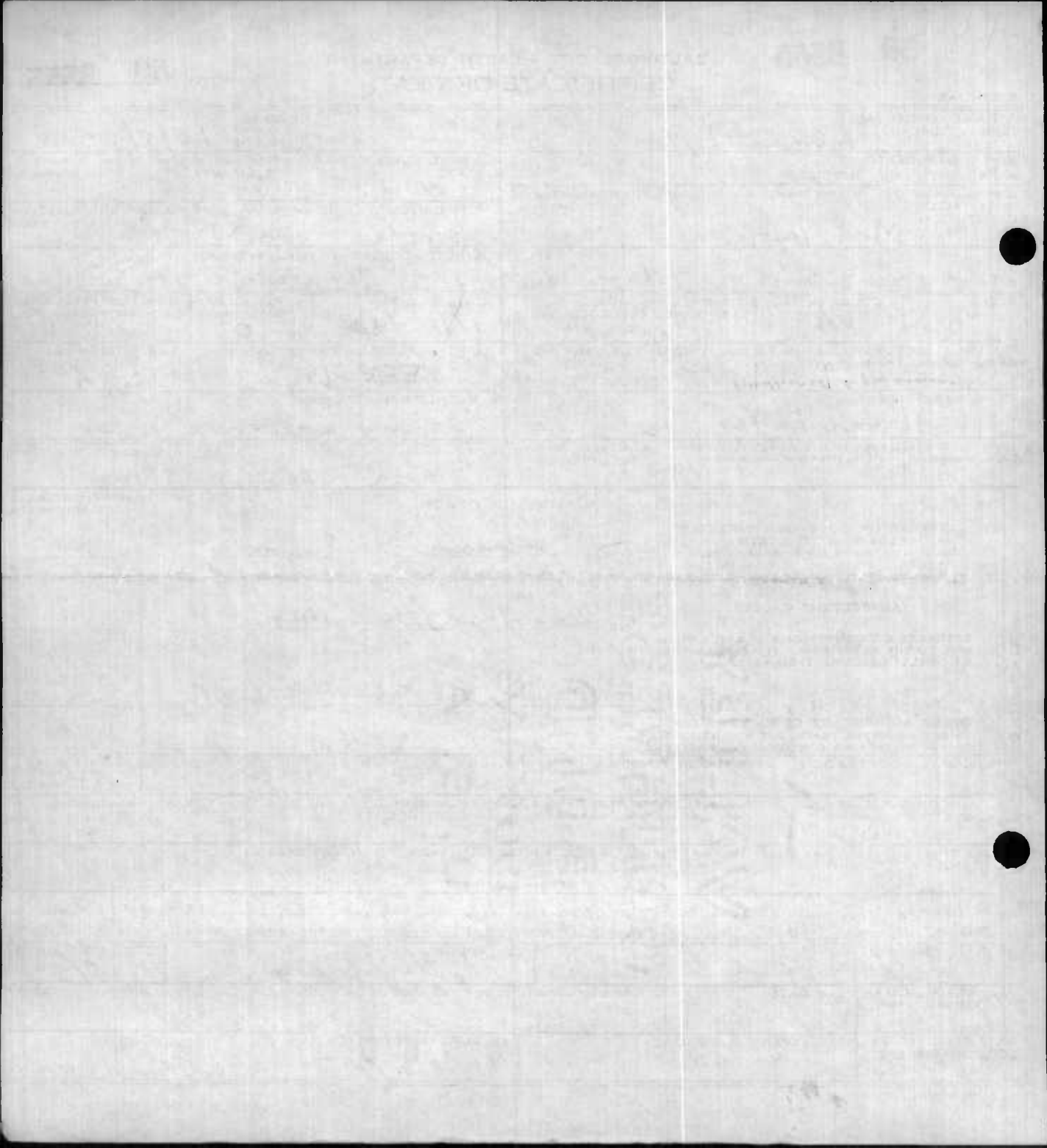
Registered No. 50 8555

BIRTH NO. 460

1. NAME OF DECEASED (Type or Print) <u>Thomas Tyler</u>		2. DATE OF DEATH <u>10/5/50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Balto.</u> <u>25-43</u>	
c. Length of stay in Baltimore <u>Life</u>		D. STREET ADDRESS (If rural, give location) <u>2409 Herkimer St.</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wht</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11/12/80</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, MACHINIST PISTON RINGS</u>		9. AGE (In years last birthday) <u>69</u> <u>70</u>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
13. FATHER'S NAME <u>William Tyler</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Edna Tyler</u>		ADDRESS <u>Same</u>	

<p>18. <u>420.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p align="center">CAUSE OF DEATH</p> <p>(A) <u>Coronary Occlusion</u></p> <p>DUE TO</p> <p>(B) <u>Generalized Arteriosclerosis</u></p> <p>DUE TO</p> <p>(C) <u>Benign Prostatic Hypertrophy</u></p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p>

19A. DATE OF OPERATION <u>10/5/50</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/3</u> , 19 <u>50</u> , to <u>10/5</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>10/5/50</u> , 19 <u>50</u> , and that death occurred at <u>8:30 A</u> m., from the causes and on the date stated above.					
23A. SIGNATURE <u>Paul F. Richardson</u>		23B. ADDRESS <u>Mercy Hosp.</u>		23C. DATE SIGNED <u>10/5/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <u>Oct 9/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>		
DATE RECEIVED BY LOCAL REGISTRAR <u>Oct 6 1950</u>	REGISTRAR'S SIGNATURE <u>Wm. J. Williams</u>	25. FUNERAL DIRECTOR <u>Harry J. Weller</u> ADDRESS <u>4101 Channing Ave</u>			





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

MOLLIE MALINDA KELLER

2. DATE  
OF  
DEATH

Oct. 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

5712 Park Heights Ave.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Md. B. COUNTY \_\_\_\_\_

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

5712 Park Heights Ave.

c. Length of stay in Baltimore

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

July 25, 1873

9. AGE (In years; last birthday)

77

10 Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John D. Childs

14. MOTHER'S MAIDEN NAME

Sophonra Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Robert K. Coscia-5712 Park Hts. Av

18. 170x

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Chronic Myocarditis

II

(C)

Carcinoma of Rt Breast

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Aug 1949, to Oct 4, 1950, that I last saw the deceased alive on Oct 3, 1950, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Albert Scagnetti

23B. ADDRESS

1729 W Lombard St

23C. DATE SIGNED

Oct 6, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/7/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24D. LOCATION (City, town, or county)

(State)

Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Dickerson & Sons - Balto, Md

VALLEY  
CONCRETE

INDUSTRIAL  
CORP.

S-3100 8557

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8557

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John J Staub

2. DATE  
OF  
DEATH

10-5-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3012 Edmondson Ave

E. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

M.

W.

M.

Sept. 30 - 1894

56

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

clerk Food Fair

11. BIRTHPLACE (State or foreign country)

Gettysburg Pa

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Jacob J. Staub

14. MOTHER'S MAIDEN NAME

Mary J. Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

218-222383

17. INFORMANT

ADDRESS

Mrs. Helen M. Staub - 3012

18. 420.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

one day

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Coronary Artery Disease

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

none

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 4, 1950, to Oct. 5, 1950, that I last saw the  
deceased alive on Oct. 5, 1950, and that death occurred at 11:55 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Martin C. Macnamara M. D.

So. Balto - Gran Hosp

Oct 5/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City/town, or county)

(State)

Burial

10/9/50

Holy Redeemer

BALTO

MD

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT - 61950

L. J. Ruck - 5325 Narford Rd.

L. J. Ruck - 5325 Narford Rd.

VS 150

3906A

094a

MEDICAL CERTIFICATION

2801745

S-452

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-20573

1. NAME OF DECEASED (Type or Print) <b>Baby Boy Salling</b>			2. DATE OF DEATH <b>Sept. 23, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>17 hr.</b>			D. STREET ADDRESS (If rural, give location) <b>1541 N. Broadway, Balto.-13</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Sept. 22, 1950</b>		9. AGE (In years last birthday) If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min. <b>17</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Sam Henry Salling</b>			14. MOTHER'S MAIDEN NAME <b>Theresa Irene Malik</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		

18. 762.5

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Oblectosis*  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

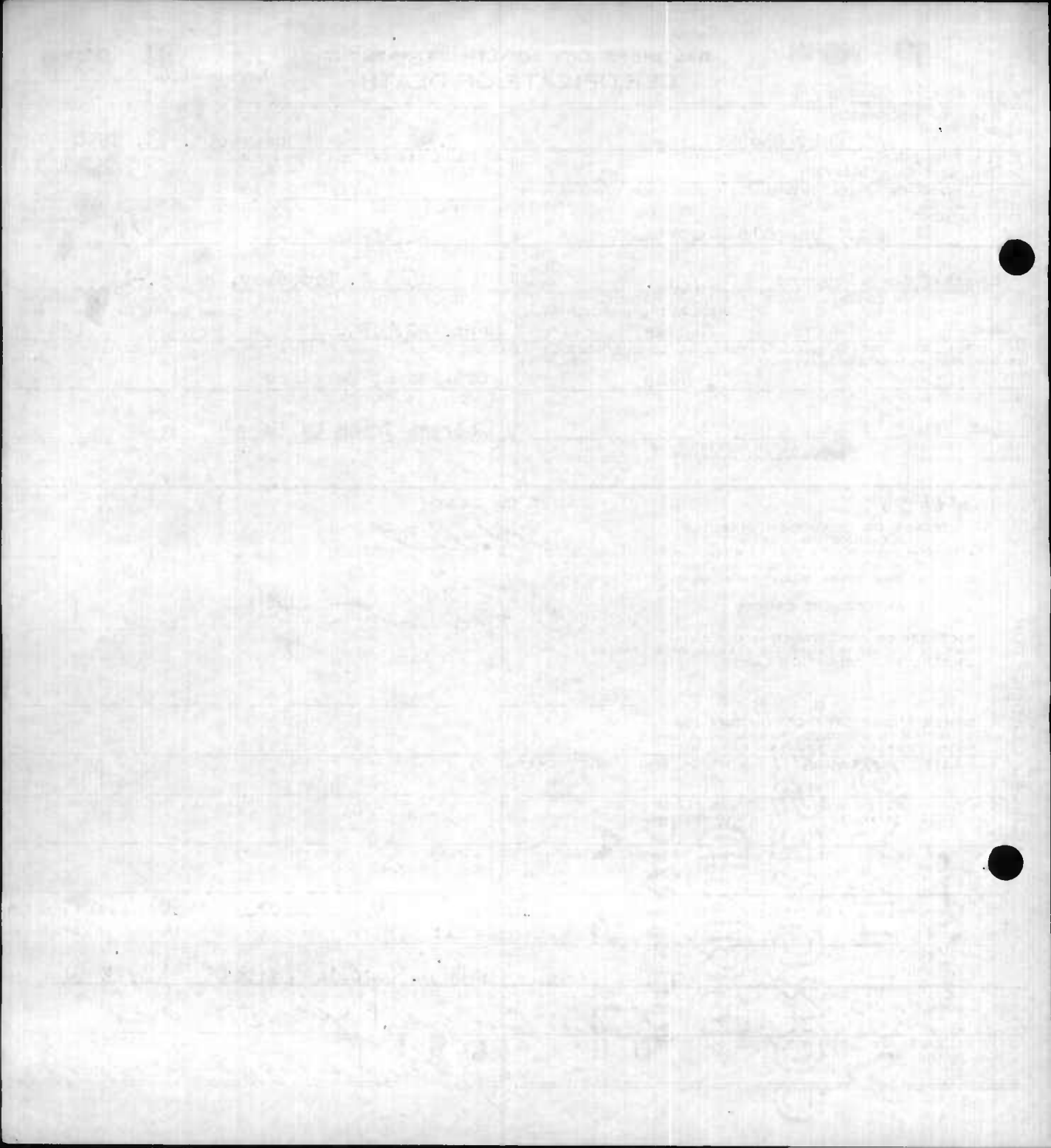
(B) *Prematurity*  
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/22/</u> , 19 <u>50</u> , to <u>8/23/</u> , 19 <u>50</u> that I last saw the deceased alive on <u>8/23/</u> , 19 <u>50</u> , and that death occurred at <u>1:35AM.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Frank W. Baker</i>		23B. ADDRESS <b>1400 N. Caroline Street</b>		23C. DATE SIGNED <b>9/23/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/8/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>Bald</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>-61950</b>		24F. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
24G. FUNERAL DIRECTOR <i>[Signature]</i>		24H. ADDRESS <b>5305 Harford</b>		24I. DATE <b>159.0</b>	





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**Mrs. Annie Bates Foreman**

2. DATE  
OF  
DEATH

**October 5, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

**Maryland**

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

**1410 Union Avenue**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore**

D. STREET ADDRESS (If rural, give location)

**1410 Union Avenue**

C. Length of stay in Baltimore

**62 years**

Yrs.  
Mos.  
Days

5. SEX

**Female**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

**Married**

8. DATE OF BIRTH

**May 25, 1864**

9. AGE (In years last birthday)

**86**

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**At Home**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Maryland**

12. CITIZEN OF  
WHAT COUNTRY?

**U S A**

13. FATHER'S NAME

**Stephen Barton**

14. MOTHER'S MAIDEN NAME

**Rebecca Barnhart**

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

**No**

16. SOCIAL  
SECURITY NO.

**---**

17. INFORMANT

**James B. Foreman**

ADDRESS

**3911 Wilkens Avenue**

18. **442X**

**CAUSE OF DEATH**

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Acute Cor. Dilation**  
DUE TO **Coronary Artery Disease**

**2 yrs**

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) **Arteriosclerosis**  
DUE TO **Coronary Artery Disease**  
(C) **Coronary Artery Disease**

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **April 1949** to **Oct 5, 1950** what I last saw the deceased alive on **Oct 3, 1950**, and that death occurred at **2 P. M.**, from the causes and on the date stated above.

23A. SIGNATURE

**13.4 L. L. L.**

M. D.

23B. ADDRESS

**3611 Falls Rd**

23C. DATE SIGNED

**Oct 6, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**Oct. 9, 1950**

24C. NAME OF CEMETERY OR CREMATORY

**St. Mary's Hampden**

24D. LOCATION (City, town, or county)

**Baltimore, Maryland**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Wm. H. Williams, Jr.**

25. FUNERAL DIRECTOR

**Burgee Funeral Home**

ADDRESS

**3631 Falls Road**

**Horace F. Burgee**

**131a**

MEDICAL CERTIFICATION

1950

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M-320

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Eltie Cordelia Mathews

2. DATE  
OF  
DEATH

October 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2041 Druid Park Drive

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2041 Druid Park Drive

C. Length of stay in Baltimore

25 years

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

March 17, 1881

9. AGE (in years  
last birthday)

69

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of worklog life, even if retired)

At Home

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Aurelius Lawson

14. MOTHER'S MAIDEN NAME

Mary E. Jennings

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

ADDRESS

Fulton A. Mathews

2041 Druid Park Drive

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Oct 25-1950

19B. MAJOR FINDINGS OF OPERATION

Carcinoma

Oct 25-1949

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK ☐AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 24, 1949 to Oct 4, 1950, that I last saw the  
deceased alive on Oct 4, 1950, and that death occurred at 8:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Benjamin Kaden

23B. ADDRESS

2306 Euter Pl

23C. DATE SIGNED

10-5-50

CREMA-  
Specify

24B. DATE

Oct. 7, 1950

24C. NAME OF CEMETERY OR CREMATORY

Prospect Hill

24D. LOCATION (City, town, or county)

Front Royal, Virginia

(State)

ED BY  
STRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Burgee Funeral Home

3631 Falls Road

Horace F. Burgee

050.0

MEDICAL CERTIFICATION

Mr. Kader  
2306 Cantan Place  
Las. 0950

H-125 8561

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Sarah E. Hobson.</i>			2. DATE OF DEATH <i>Oct. 5, 1950.</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Crawford Retreat 2117 Denison Street</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>13-06</i>		
c. Length of stay in Baltimore <i>62 years</i>			D. STREET ADDRESS (If rural, give location) <i>813 Wellington Street</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>June 23, 1872</i>	9. AGE (In years, last birthday) <i>78</i>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bundle Wrapper</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Mt. Vernon-Woodberry Mills</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>			13. FATHER'S NAME <i>William Henry Hobson</i>		
14. MOTHER'S MAIDEN NAME <i>Agnes Ann Greene</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		
16. SOCIAL SECURITY NO. <i>215-07-6429</i>			17. INFORMANT ADDRESS <i>Mrs. Nellie M. Boyer 3642 Hickory Avenue</i>		

18. *141X*

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) *Carcinoma of the tongue and throat.*

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *?*

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) *Chronic Hypertension + Chronic cardiac vascular disease* *Unknown.*

19A. DATE OF OPERATION <i>None</i>		19B. MAJOR FINDINGS OF OPERATION <i>✓</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *Sept. 14, 1950*, to *Oct. 5, 1950*, that I last saw the deceased alive on *Oct. 5, 1950*, and that death occurred at *4:25 P.M.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Frank N. Opler</i>	23B. ADDRESS <i>2701 N. Calvert St.</i>	23C. DATE SIGNED <i>Oct. 5, '50</i>
---	--	--

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Oct. 9, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore Co., Maryland</i>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>William M. Williams</i>		25. FUNERAL DIRECTOR ADDRESS <i>Burgee Funeral Home 3631 Falls Road</i>

OCT 1950 61950

*Horace F. Burgee*

0456

Oct 2, 1935

Chas. H. Johnson

1000

0

812 West 10th Street

June 24, 1935

D 2 A

Kingdom

John and Green

100-07-1000 Mrs. Nellie M. Boyer 3021 Lakota Avenue

Commission of the General and Special

United States Department of State

Various records of the Department

July 11, 1935 100-07-1000

Chas. H. Johnson 1000

100-07-1000 1000

100-07-1000 1000



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Martha Houchins*

2. DATE  
OF  
DEATH

*10-2-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*Provident Hospital*

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

*MD.*

*Balto City*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore 17-01*

D. STREET ADDRESS (If rural, give location)

*678 Pierce St.*

C. Length of stay in Baltimore

*7*

5. SEX

*F*

6. COLOR OR RACE

*C*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Married (separated)*

8. DATE OF BIRTH

*7-7-25*

9. AGE (in years last birthday)

*25*

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Fountain, N.C.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.*

13. FATHER'S NAME

*Manuel Rogers*

14. MOTHER'S MAIDEN NAME

*Bessie Bullock*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Martha Houchins (above)*

18. *019.2*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

*Military Tuberculosis*

*2 yrs*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *9-7-1950* to *10-2-1950*, that I last saw the deceased alive on *10-2-50*, and that death occurred at *6:30 p.m.* from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

*Provident Hosp.*

*10/5/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

*Shipped*

*Oct. 6, 1950*

*Wilson*

*N.C.*

*Wilson, N.C.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*VS 150*

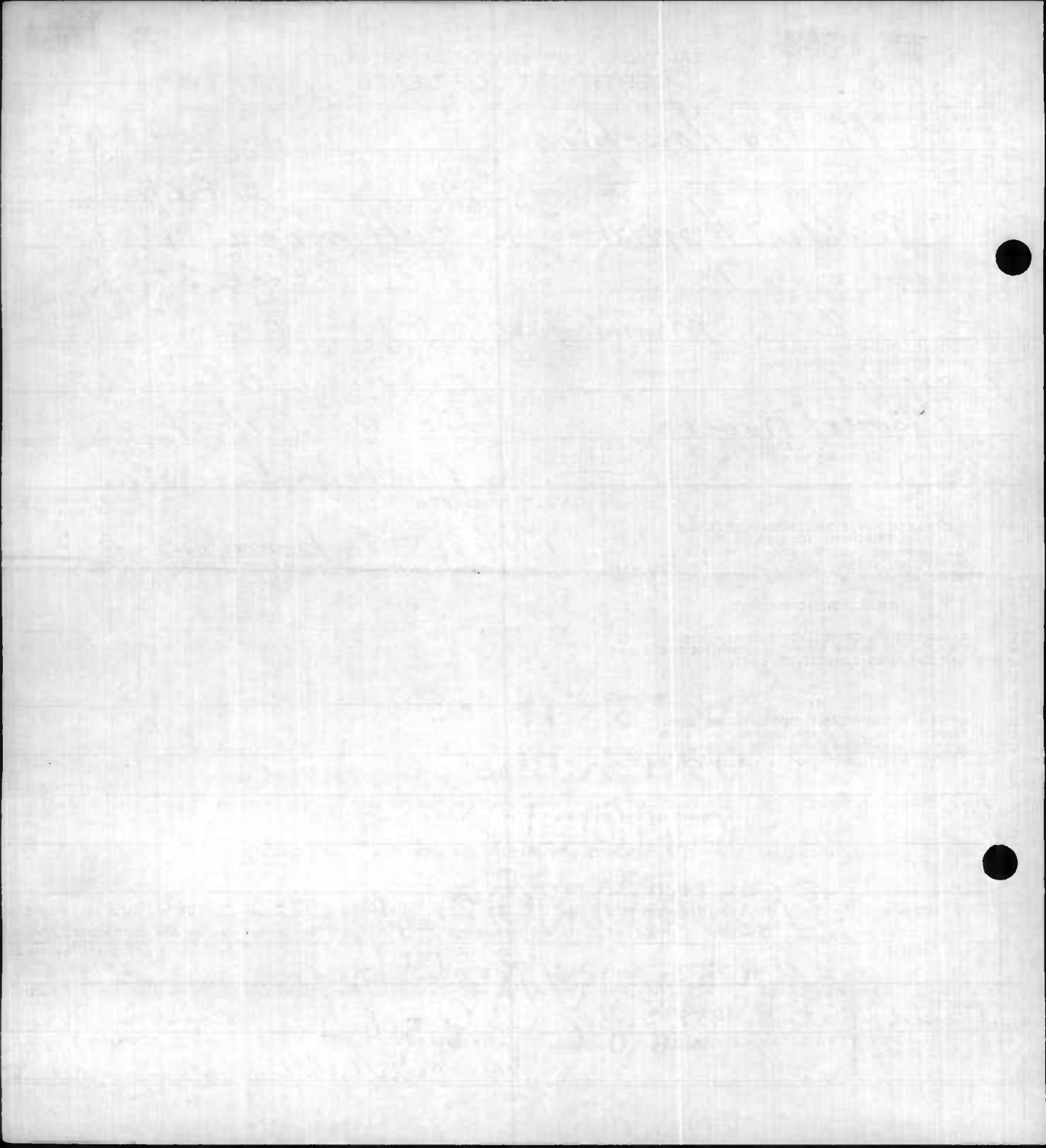
*Martha Houchins*

*Mrs. Katie R. Williams*

*322 N. Schreder St.*

*013B*

MEDICAL CERTIFICATION



H-400 8563

50 8563

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Annie Beatrice Hall</b>		2. DATE OF DEATH <b>Oct. 2, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>416 N. Calhoun St.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Balto.</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>416 N. Calhoun St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto.</b> <b>19-01</b>	
c. Length of stay in Baltimore <b>47</b>		D. STREET ADDRESS (If rural, give location) <b>416 N. Calhoun St.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 3, 1903</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>47</b>
13. FATHER'S NAME <b>George Gent</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Janie Brauner</b>	
17. INFORMANT <b>Marion J. Hall</b>		ADDRESS <b>416 N. Calhoun St.</b>	

18. <b>331X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hypertension</b>		<b>?</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Sept 24**, 19**50**, to **Oct 2**, 19**50**, that I last saw the deceased alive on **Oct 1**, 19**50**, and that death occurred at **2:30** m., from the causes and on the date stated above.

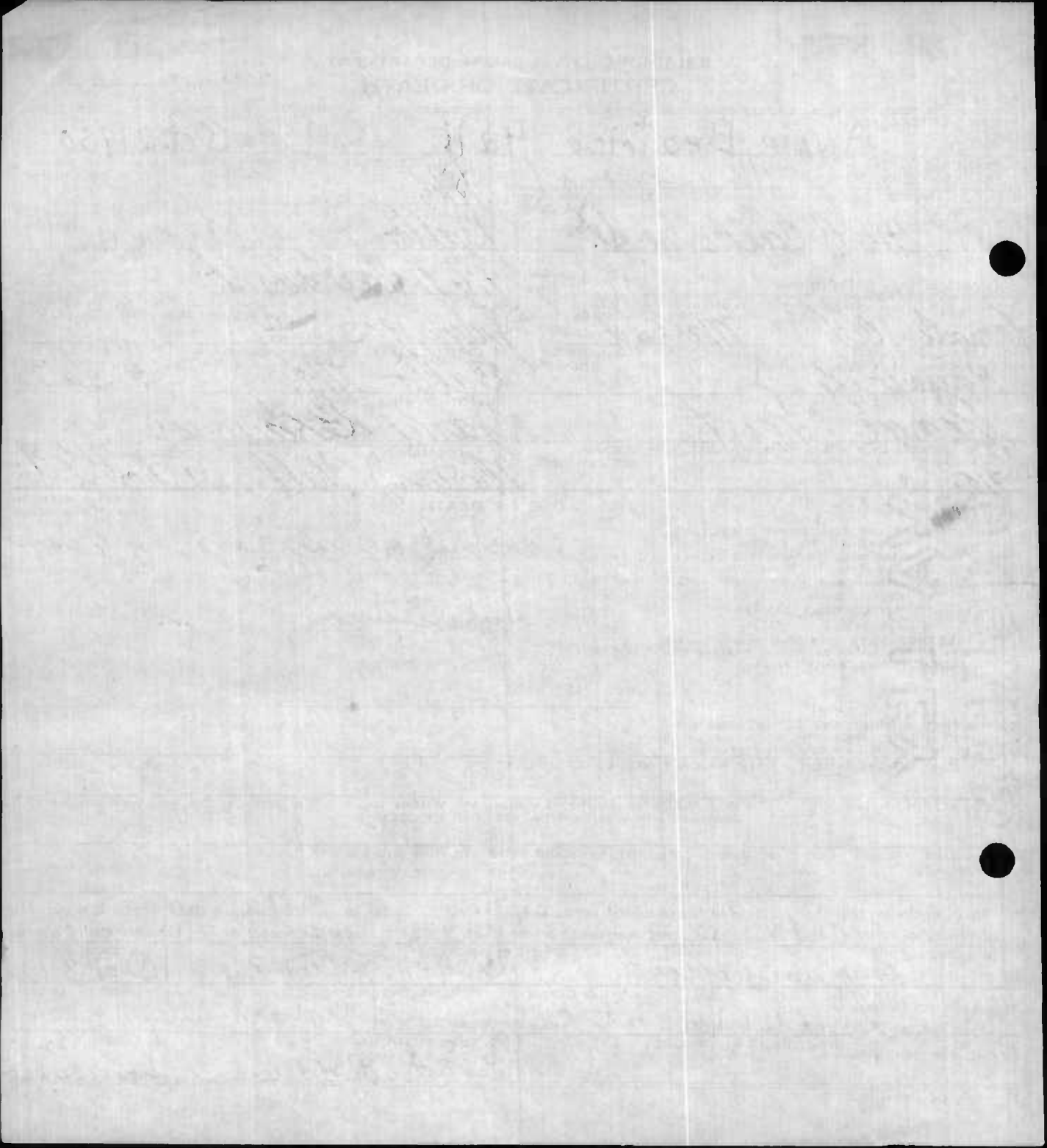
23A. SIGNATURE <b>J. Douglas Sheppard</b>	23B. ADDRESS <b>604 N. Fulton Ave</b>	23C. DATE SIGNED <b>Oct 3 1950</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>October 6, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>mt. Calvary</b>	24D. LOCATION (City, town, or county) (State) <b>Cedar Hill, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR <b>Mrs. Katie R. Williams</b>	ADDRESS <b>322 N. Schuylkill St.</b>

OCT 7 1950

083a

MEDICAL CERTIFICATION

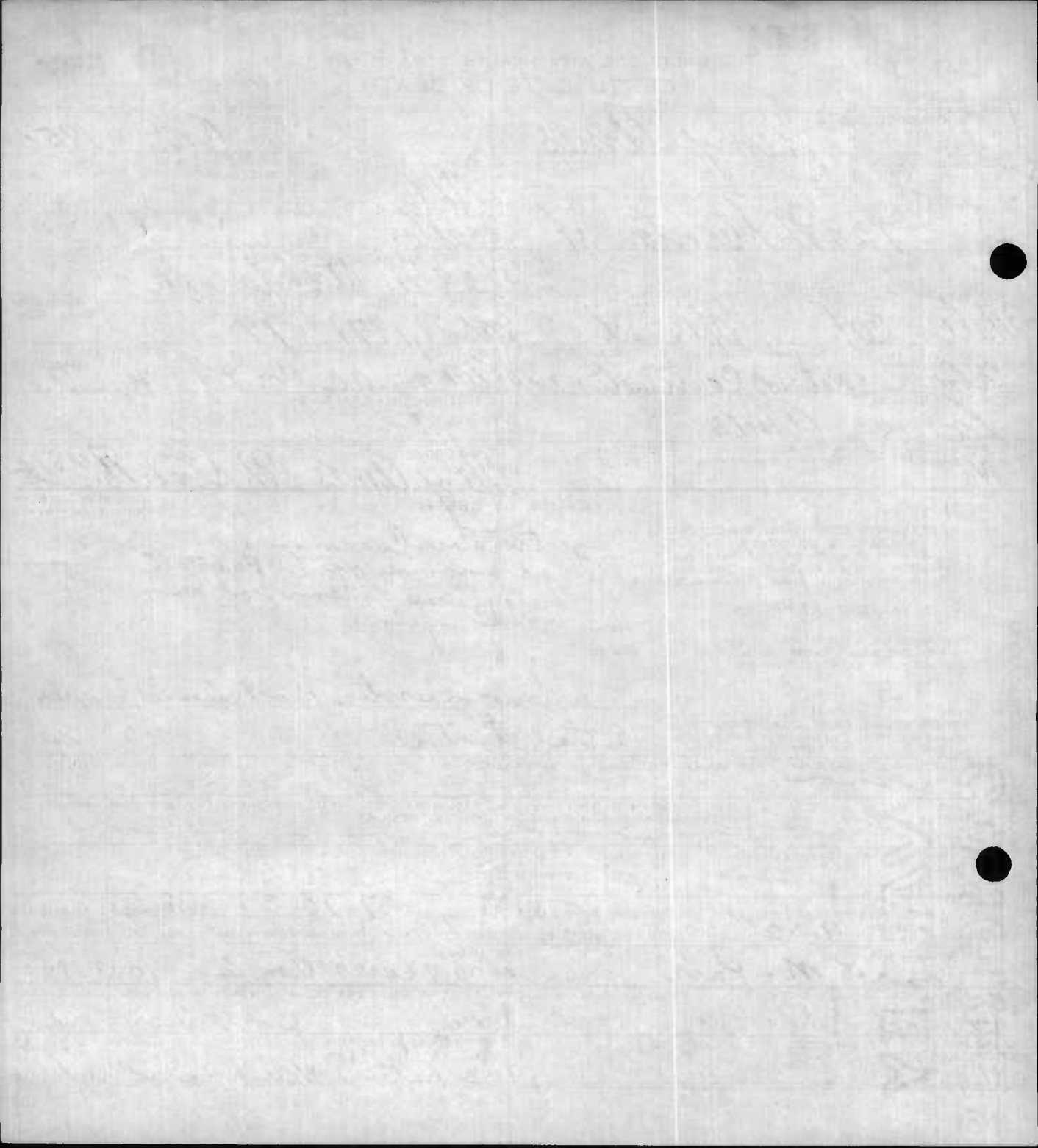


A-520

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Henry Ames</i>		2. DATE OF DEATH <i>Oct. 3, 1950</i>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Baltimore</i>	
b. FULL NAME OF HOSPITAL OR INSTITUTION <i>728 N. Stockton St.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore Yrs. <i>0</i> Mos. <i>0</i> Days <i>0</i>		d. STREET ADDRESS (If rural, give location) <i>728 N. Stockton St.</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>May 1, 1871</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labourer (Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction Work</i>	9. AGE (In years, last birthday) <i>79</i>
11. BIRTHPLACE (State or foreign country) <i>Accomac Co. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Louis Ames</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Mary Ames</i>		ADDRESS <i>728 N. Stockton St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>metastatic Carcinoma</i> DUE TO <i>Carcinoma of the Prostate</i> <i>metastasis to Bones of pelvis and spine</i> (B) _____ DUE TO _____ (C) <i>arteriosclerotic heart disease</i> <i>Rectal stricture</i>	
19a. DATE OF OPERATION <i>9</i>		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21d. TIME (Month) (Day) (Year) (Hour) INJURY _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <i>5.5</i> <i>1937</i> to <i>10.3</i> , 1950, that I last saw the deceased alive on <i>9.30</i> , 1950, and that death occurred at <i>4 p. m.</i> , from the causes and on the date stated above.			
23a. SIGNATURE <i>James M. Pair</i>		23b. ADDRESS <i>400 N. Carrollton Ave</i>	
23c. DATE SIGNED <i>10.5.1950</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>October 7, 1950</i>	
24c. NAME OF CEMETERY OR CREMATORY <i>mt. Auburn</i>		24d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT - 6 1950</i>		REGISTRAR'S SIGNATURE <i>Mr. Katie R. Williams</i>	
FUNERAL DIRECTOR <i>Mr. Katie R. Williams</i>		ADDRESS <i>322 N</i>	





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 8565

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>HARRY CARTER</b>		2. DATE OF DEATH <b>October 1, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Maryland General Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
Length of stay in Baltimore <b>20</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>525 N. Gilmore Street</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Oct. 22, 1910</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction Work</b>	9. AGE (In years last birthday) <b>39</b>
11. BIRTHPLACE (State or foreign country) <b>Nottaway, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Carter</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jenkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Henrietta Cobbs</b>		ADDRESS <b>1066 W. Fayette St.</b>	

18. <b>322.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute alcoholism</b> DUE TO (A) _____ (B) _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>10-7-1950</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>Stanley H. Dunsen</i> M.D.		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED <b>10-2-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>10-7-1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Paul's</b>	
24D. LOCATION (City, town, or county) <b>Balto</b>		24E. STATE <b>MD</b>		24F. GENERAL DIRECTOR <i>W. H. Williams</i>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>W. H. Williams</i>		ADDRESS <b>322</b>	

MINISTRY OF HEALTH  
CERTIFICATE OF DEATH

DATE OF DEATH  
TIME OF DEATH

Name of Deceased		Sex		Age	
Place of Birth		Date of Birth		Time of Birth	
Usual Residence		Occupation		Cause of Death	
Signature of Doctor		Signature of Registrar		Signature of Coroner	

CAUSE OF DEATH

Immediate Cause		Underlying Cause		Contributing Cause	
Manner of Death		Place of Death		Time of Death	
Signature of Doctor		Signature of Registrar		Signature of Coroner	

F-500

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Catherine Finn

2. DATE OF DEATH  
Oct. 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

3207 Piedmont Ave.,

60-- Yrs.

C. Length of stay in Baltimore

Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
Md.C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

3207 Piedmont Ave.,

8. DATE OF BIRTH

Sept. 27, 1861

9. AGE (In years last birthday)

89

H Under 1 Year Months: Days

H Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.Y.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Philip Zervas

14. MOTHER'S MAIDEN NAME

Louise Gerdon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Mrs. Margaret Whittemore

ADDRESS

3207 Piedmont Av

1B. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis, chronic

6-7 yrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardiovascular disease

25 yrs

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

multiple ulcer, infarct

6 wks

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER- Lying ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1947, 19 to Oct 4, 1950, that I last saw the deceased alive on Oct 4, 1950, and that death occurred at 5:20 A. m., from the causes and on the date stated above.

23A. SIGNATURE

M. O.

23B. ADDRESS

2835 Guyman Falls Pkwy

23C. DATE SIGNED

10/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-7-1950

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county) (State)

Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

G. Howard Strong 3207 W. North Ave.,

0932

Dr. Daniel R. Robinson  
2835 Huron Street, Chicago  
La 8984

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Spencer Thomas*

2. DATE  
OF  
DEATH

*10 - 3 - 50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore, Maryland*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *Maryland*

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

*South Baltimore General Hospital*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore*

*16-01*

D. STREET ADDRESS (If rural, give location)

*1027 W. Hanuale Street*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*Male*

6. COLOR OR RACE

*Colored*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Married*

8. DATE OF BIRTH

*3/12*

9. AGE (in years last birthday)

*56*

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Wood - Cutter*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Maryland*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*John Thomas*

14. MOTHER'S MAIÖEN NAME

*Molly Speaks*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

*2-16-16-2031*

17. INFORMANT

ADDRESS

18. *443X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Cerebro vascular hemorrhage* *four days*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Hypertensive cardiovascular disease* *many years*

DUE TO

(C) *arteriosclerosis* *many years*

INTERVAL BETWEEN ONSET AND DEATH

11  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Apr. 29*, 19*50*, to *Oct 3*, 19*50*, that I last saw the deceased alive on *Oct 3*, 19*50*, and that death occurred at *1:55 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Agustín del Campo*

M. D.

23B. ADDRESS

*South Balto Gen. Hospital*

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*Oct 6 50*

24C. NAME OF CEMETERY OR CREMATORY

*But Calvary Ct*

24D. LOCATION (City, town, or county)

*A. A. Co. Md*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*William H. Williams*

25. FUNERAL DIRECTOR

*108 W 2050 John Montgomery St*

ADDRESS

VS 150

97031

0932

MEDICAL CERTIFICATION

2nd of May 1892  
Dear Sir,

My dear Sir,

I have the pleasure to inform you that

the same has been forwarded to you

by the same conveyance as the other

papers of the same nature

which I have the honor to acknowledge

of the 1st inst.

and I am, Sir, very respectfully,

Yours faithfully,

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Joseph F. Powers</i>			2. DATE OF DEATH <i>10/3/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
c. Length of stay in Baltimore <i>Life</i>			D. STREET ADDRESS (If rural, give location) <i>419 Murdock Rd. 5300</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>Wht</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>3/7/1892</i>	9. AGE (In years last birthday) <i>58</i>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auditor - State</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>State Government</i>	11. BIRTHPLACE (State or foreign country) <i>Balto, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John Powers</i>			14. MOTHER'S MAIDEN NAME <i>Johanna Lewis</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Helena Powers Same</i>		

1B. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Acute Myocardial Infarction</i> DUE TO  (B) _____ DUE TO  (C) _____	INTERVAL BETWEEN ONSET AND DEATH <i>13 days</i>
---	--	--

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *Sept 20, 1950*, to *Oct 3, 1950*, that I last saw the deceased alive on *Oct 3, 1950*, and that death occurred at *6:45 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE *Paul J. Richardson* M. D. 23B. ADDRESS *Mercy Hospital* 23C. DATE SIGNED *Oct 3, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Reinterment</i>	24B. DATE <i>10-7-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>St. Johns Long Green</i>	24D. LOCATION (City, town, or county) (State) <i>BALTO. Co. Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT - 6 1950</i>	REGISTRAR'S SIGNATURE <i>William J. Williams</i>	25. FUNERAL DIRECTOR ADDRESS <i>Greenmount x 22</i>	



5-543

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Owen Melvin Smallwood Sr.

2. DATE  
OF  
DEATH

Oct. 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

8. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION location)

Johns Hopkins Hosp. (D O A)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

532 N. Curley St.

c. Length of stay in Baltimore

life

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Nov. 8, 1892

9. AGE (In years last birthday)

57

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Officer

10B. KIND OF BUSINESS OR INDUSTRY

Balto. Police Dept.

11. BIRTHPLACE (State or foreign country)

Howard County, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

John L. Smallwood

14. MOTHER'S MAIDEN NAME

Martha A. Smallwood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

ADDRESS

Gertrude L. Smallwood, wife, above

18. E976X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Gunshot wound, head

## ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Yard of Balto. Brick Co.

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

Beltway Highway &amp; Madison Street

21D. TIME (Month) (Day) (Year) (Hour) (Minute)

Oct. 4, 1950 4:15 P.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Self Inflicted Firearms 26/4

22. I certify that I took charge of the remains described above, held them thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

John R. Davis M.D.

M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

10/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 7, 1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem.

24D. LOCATION (City, town, or county) (State)

4430 Belair Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William A. Williams

25. FUNERAL DIRECTOR

Schmuck General Home, Inc. 2601-3-5 E. Madison St.

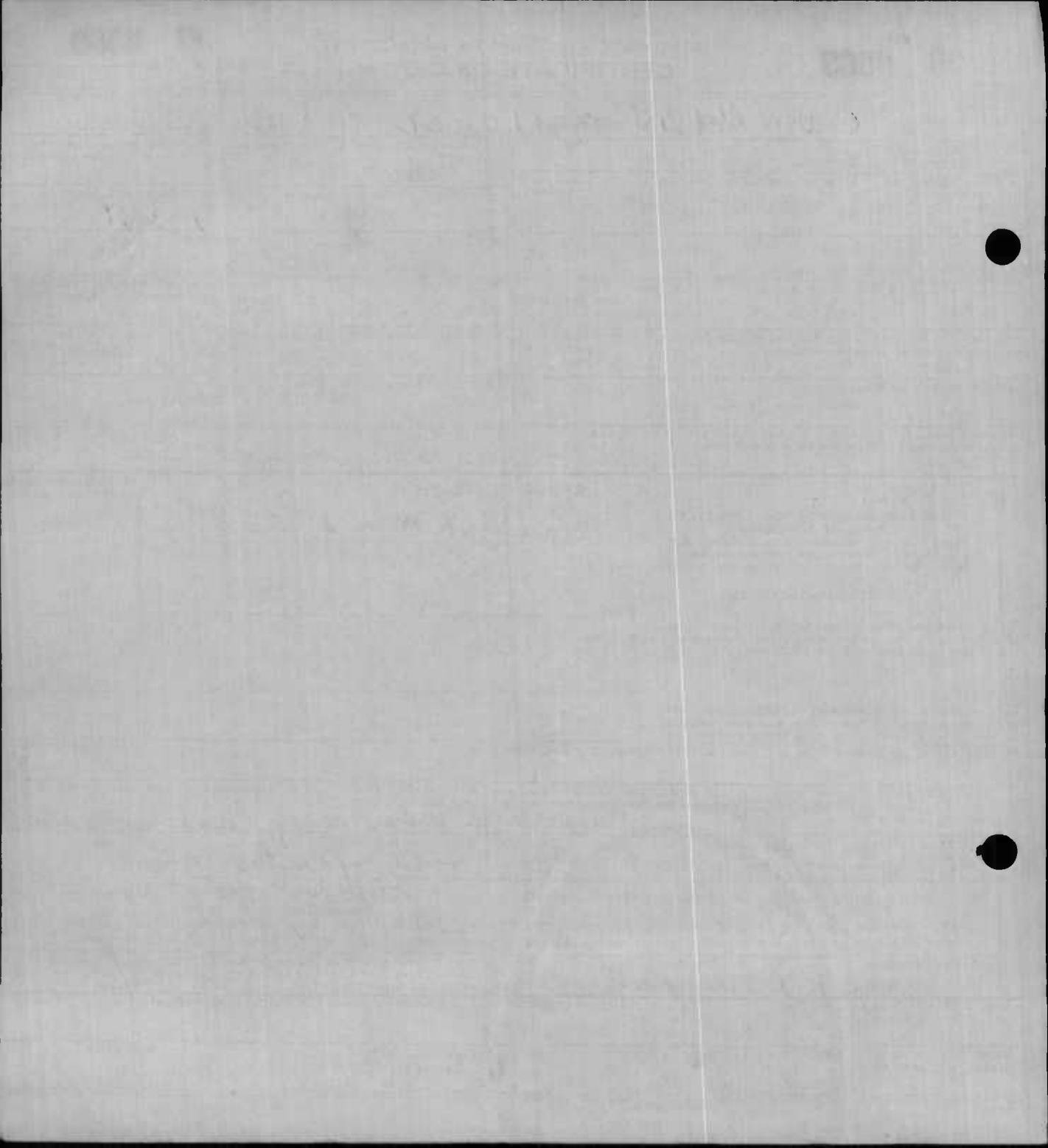
ADDRESS

VS 151

N 853.4

773 93

164C



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 8570

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>JOHN F. PROEBSTL</b>			2. DATE OF DEATH <b>October 3, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>7-02</b>		
c. Length of stay in Baltimore <b>22 years</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>513 N. Rose Street</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Mar. 26, 1898</b>		9. AGE (In years last birthday) <b>52</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>American Brewery</b>	11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>Germany</b>
13. FATHER'S NAME <b>Frank Proebstl</b>			14. MOTHER'S MAIDEN NAME <b>Mary Schaeffer</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mrs. Cenci Proebstl, wife, above</b>		

<p>18. <b>E974.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Asphyxia due to hanging</b> (A) _____ DUE TO _____ (B) _____ DUE TO _____ (C) _____</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p>
--	---

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>513 N. Rose Street</b>	
21D. TIME (Month) (Day) (Year) (Hour) <b>October 3, 1950 ? P m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Hanged self by rope suspended from transom</b>	
<p>22. I certify that I took charge of the remains described above, held an <b>Insp. &amp; Inquiry</b> thereon and from <b>Autopsy, Inspection or Inquiry</b> the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/>, accident <input type="checkbox"/>, suicide <input checked="" type="checkbox"/>, homicide <input type="checkbox"/>, undetermined <input type="checkbox"/>.</p>					
23A. SIGNATURE <i>[Signature]</i>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER.....		23C. DATE SIGNED <b>10-4-50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>9 5 4750 Belair Rd. Baltimore</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>2601-5-5 E. Madison St.</b>	

VS 151 **N991X** **970 46** **164a** ✓

MEDICAL CERTIFICATION

1970

1970

STATE OF NEW YORK  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of funeral director	
13. Signature of medical examiner		14. Signature of coroner		15. Signature of jury	
16. Signature of health officer		17. Signature of local health officer		18. Signature of local health officer	
19. Signature of local health officer		20. Signature of local health officer		21. Signature of local health officer	
22. Signature of local health officer		23. Signature of local health officer		24. Signature of local health officer	
25. Signature of local health officer		26. Signature of local health officer		27. Signature of local health officer	
28. Signature of local health officer		29. Signature of local health officer		30. Signature of local health officer	
31. Signature of local health officer		32. Signature of local health officer		33. Signature of local health officer	
34. Signature of local health officer		35. Signature of local health officer		36. Signature of local health officer	
37. Signature of local health officer		38. Signature of local health officer		39. Signature of local health officer	
40. Signature of local health officer		41. Signature of local health officer		42. Signature of local health officer	
43. Signature of local health officer		44. Signature of local health officer		45. Signature of local health officer	
46. Signature of local health officer		47. Signature of local health officer		48. Signature of local health officer	
49. Signature of local health officer		50. Signature of local health officer		51. Signature of local health officer	
52. Signature of local health officer		53. Signature of local health officer		54. Signature of local health officer	
55. Signature of local health officer		56. Signature of local health officer		57. Signature of local health officer	
58. Signature of local health officer		59. Signature of local health officer		60. Signature of local health officer	
61. Signature of local health officer		62. Signature of local health officer		63. Signature of local health officer	
64. Signature of local health officer		65. Signature of local health officer		66. Signature of local health officer	
67. Signature of local health officer		68. Signature of local health officer		69. Signature of local health officer	
70. Signature of local health officer		71. Signature of local health officer		72. Signature of local health officer	
73. Signature of local health officer		74. Signature of local health officer		75. Signature of local health officer	
76. Signature of local health officer		77. Signature of local health officer		78. Signature of local health officer	
79. Signature of local health officer		80. Signature of local health officer		81. Signature of local health officer	
82. Signature of local health officer		83. Signature of local health officer		84. Signature of local health officer	
85. Signature of local health officer		86. Signature of local health officer		87. Signature of local health officer	
88. Signature of local health officer		89. Signature of local health officer		90. Signature of local health officer	
91. Signature of local health officer		92. Signature of local health officer		93. Signature of local health officer	
94. Signature of local health officer		95. Signature of local health officer		96. Signature of local health officer	
97. Signature of local health officer		98. Signature of local health officer		99. Signature of local health officer	
100. Signature of local health officer		101. Signature of local health officer		102. Signature of local health officer	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 8571

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MARY URBANCIK</b>			2. DATE OF DEATH <b>October 4, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>8-04</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Sinai Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>55 years</b>			D. STREET ADDRESS (If rural, give location) <b>2231 E. Chase Street</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Feb. 2, 1877</b>		9. AGE (In years last birthday) <b>73</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>unknown</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Geo. F. Urbancik, son, 5311 Pembroke Ave.</b>		

**CAUSE OF DEATH**

<p>18. <b>E 812.4</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p align="center"><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p>
<p>(A) <b>Rupture of liver with intraperitoneal hemorrhage</b></p> <p>(B) <b>Compound comminuted fracture of right tibia and fibula</b></p> <p>(C) <b>Fracture of pelvis</b></p> <p>(D) <b>Multiple contusions and abrasions</b></p>	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., to or about home, farm, factory, street, office bldg., etc.) <b>street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Patterson Park Ave. near Monument St.</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>October 3, 1950 1.00p m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Pedestrian struck by automobile</b>	

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>William V. [Signature]</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>October 4, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Oct. 7, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>4430 Belair Rd. Baltimore, Md.</b>		
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR ADDRESS <b>Scindler Funeral Home, Inc. 2601-3-5 E. Madison St.</b>		



C-640

50 8572

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8572

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John Carroll

2. DATE  
OF  
DEATH

Oct. 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 923 N. Belnord Ave.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Md. B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 7-02

D. STREET ADDRESS (If rural, give location)

923 N. Belnord Avenue

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
single

8. DATE OF BIRTH

July 28, 1925

9. AGE (In years  
last birthday)

25

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Machine Operator

10B. KIND OF BUSINESS OR  
INDUSTRY

Coca Cola Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.

13. FATHER'S NAME

Robert Carroll

14. MOTHER'S MAIDEN NAME

Marie Kokta

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or ookoowo) (If yes, give war or dates of service)

yes

navy - #2

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Marie Carroll, mother, above

18. 42011

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertensive V D

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

1948.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1948, to Oct 5, 1950 that I last saw the  
deceased alive on Oct 4, 1950, and that death occurred at 5 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Lawrence J. Schuman M. D.

23B. ADDRESS

3811 Falls Rd

23C. DATE SIGNED

10-3-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

10-9-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem.

24D. LOCATION (City, town, or county)

4450 Belair Rd. Balto. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Schumnek Funeral Home, Inc.

8 2801-3-50 E. Madison St.

OCT 15 1950

Washington, D. C.

69046

0932

MEDICAL CERTIFICATION

1945

1946

1947

1948



L-250

REA-142204

*Ligon*  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8573BIRTH NO. 50 85731. NAME OF DECEASED  
(Type or Print)Nellie Alberta Ligon2. DATE  
OF DEATHOctober 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balti. City

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MarylandB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTIONBaltimore City Hospitals  
4940 Eastern Avenue

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1615 Lawrence Street

c. Length of stay in Baltimore

30 yrs.Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Negro7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)Married

8. DATE OF BIRTH

Dec. 29, 19039. AGE (In years  
last birthday)4610 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRYHousewifeat Home

13. FATHER'S NAME

Washington Lambert

11. BIRTHPLACE (State or foreign country)

Virginia12. CITIZEN OF  
WHAT COUNTRY?U. S. A.

14. MOTHER'S MAIDEN NAME

Rebecca Carter15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)no16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Records: B. C. H. 4940 Eastern Avenue18. 443x

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive Cardio Vascular Disease4 Months

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 10-3, 1950, to 10-5, 1950, that I last saw the  
deceased alive on 10-5, 1950, and that death occurred at 11:20P m., from the causes and on the date stated above.

23A. SIGNATURE

H. Ligon

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

10-6-5024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

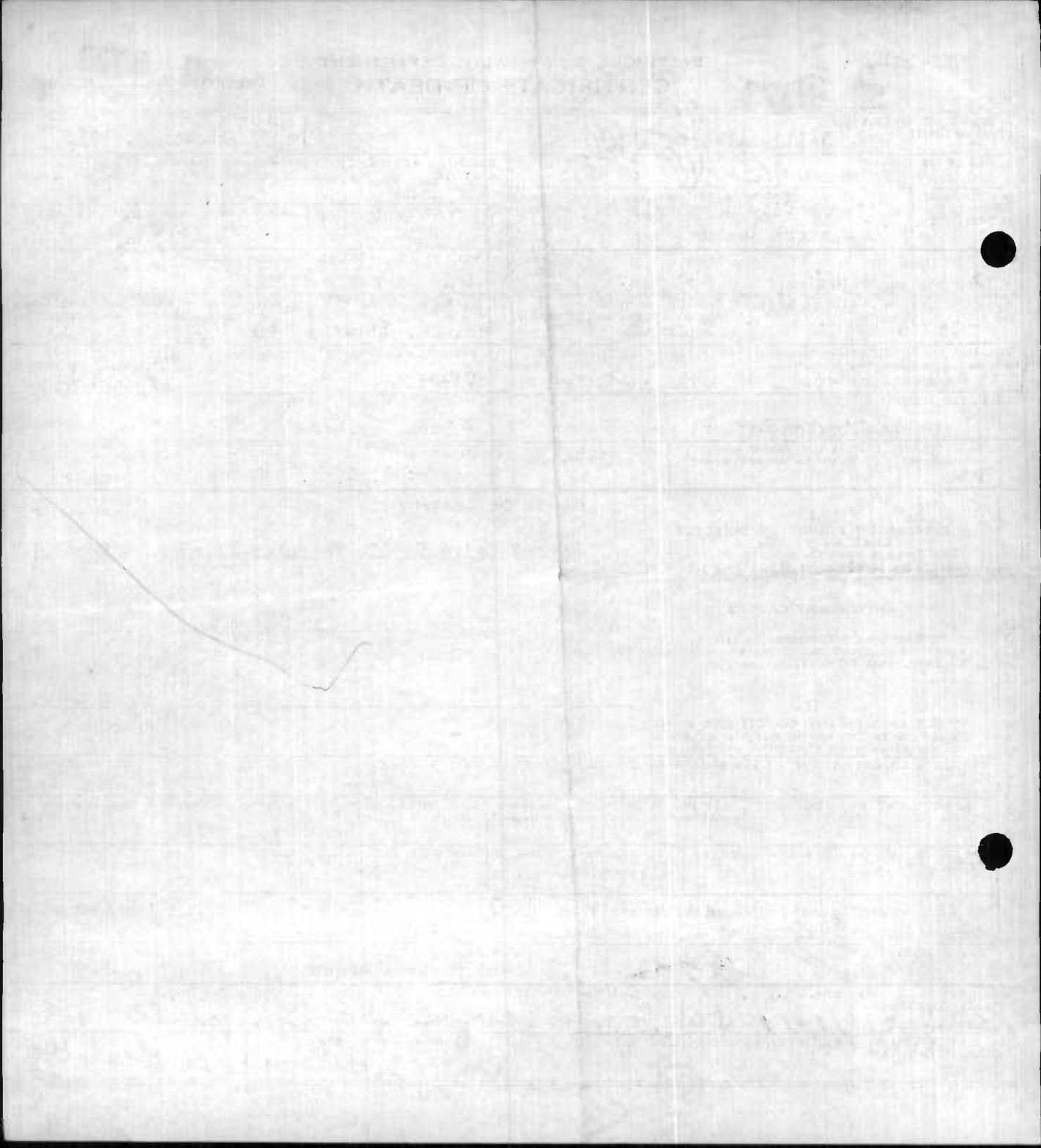
25. FUNERAL DIRECTOR

ADDRESS

Burial10-11-50Farmville - Farmville VaChas. S. Wilcox 1000 BroadlyatOCT-6-1950

VS 150

093d





J-250  
REA-140972BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8574  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William H. Jackson

2. DATE

OF DEATH Oct. 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE Baltimore City Hospitals  
4940 Eastern Avenue4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland  
B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 5-01D. STREET ADDRESS (If rural, give location)  
1129 E. Lexington Street

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Janitor

10B. KIND OF BUSINESS OR INDUSTRY

Apt. House

13. FATHER'S NAME

William Jackson

8. DATE OF BIRTH

Dec. 7 1885

9. AGE (In years last birthday)

64

11 Under 1 Year Months: Days  
11 Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

14. MOTHER'S MAIDEN NAME

Mary Cole

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Records: B. C. H. 4940 Eastern Avenue

18. 002X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculosis of lung and brain (gross Post-mortem diagnosis)  
DUE TO

Unknown

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 8-24, 1950, to 10-3, 1950, that I last saw the deceased alive on 10-3-50, 1950, and that death occurred at 9 P. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D. 4940 Eastern Avenue

10-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

10/9/1950

Mt Calvary Cem.

Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 10 1950

VS 150

77074

0136

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

APRIL 1, 1899

ALBANY:

JOHN P. KANE, PRINTER

1901

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5-363

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

STEWART

Myrtle Stewart

2. DATE  
OF  
DEATH

Oct 4 / 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

Balto - Md

b. FULL NAME OF  
(If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

416 N. Ann. St

c. Length of stay in Baltimore

21 yrs.

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)Female  
Caucasian

widow

10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Joseph Mabele

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

5-16-1906

9. AGE (In years  
last birthday)

44

11. BIRTHPLACE (State or foreign country)

D.C., Md.

12. CITIZEN OF  
WHAT COUNTRY?  
USA

14. MOTHER'S MAIDEN NAME

Rosa Bordley

17. INFORMANT

ADDRESS

Lillian Stewart 416 N. Ann St

18. 42211

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebral Hemorrhage

2 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

Coronary Vascular

Indef.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

WHILE AT ☐NOT WHILE  
AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 3 1950, to Oct 4, 1950 that I last saw the  
deceased alive on Oct 4, 1950, and that death occurred at 10:20 p. m., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

J. Edward Fisher

M. D.

1612 E. Monument

10-5-50

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

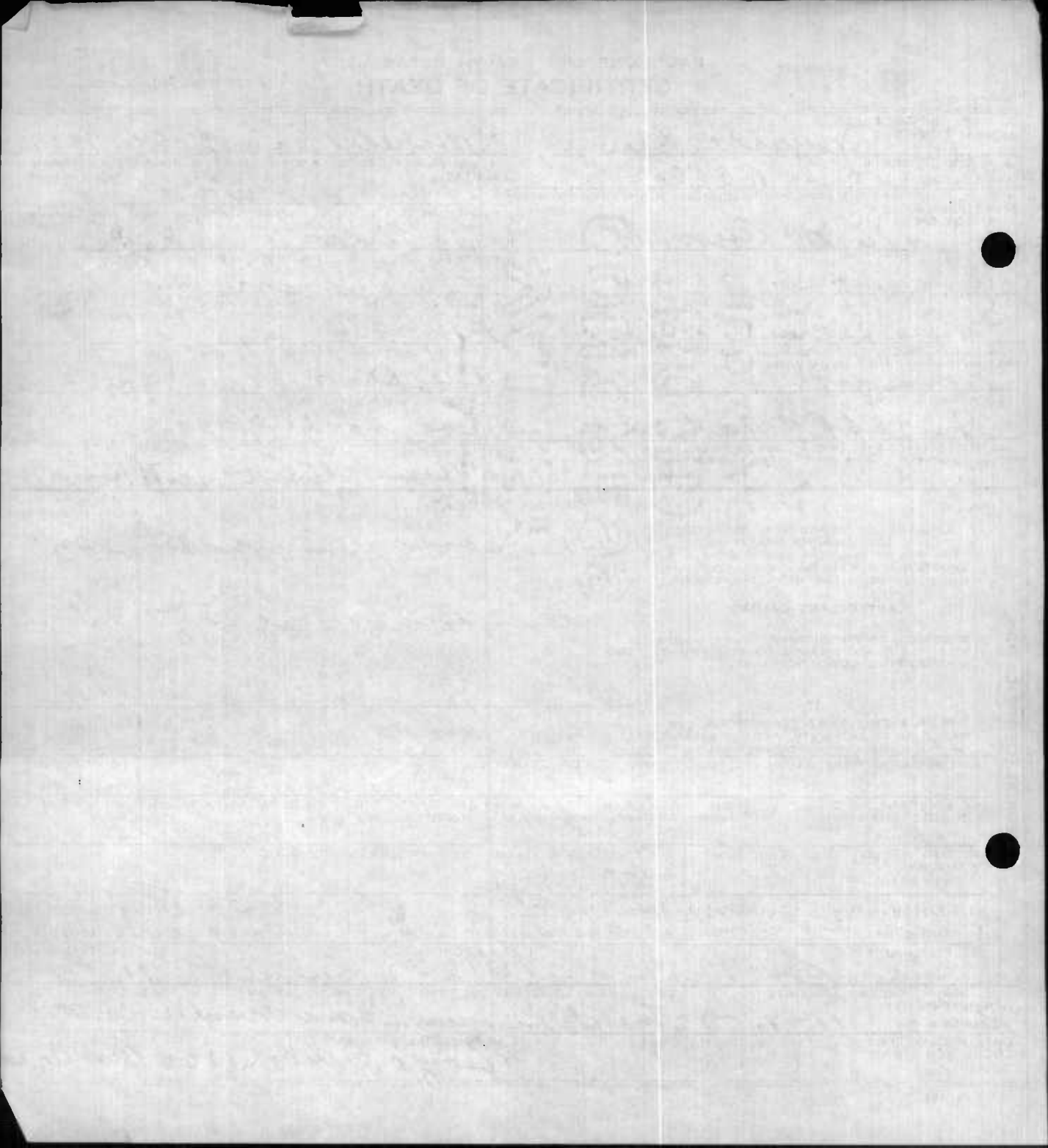
DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 6 1950



D-243

50 8576

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Emma DA Shields

2. DATE  
OF  
DEATH

10/5/50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

17-03

d. STREET ADDRESS (If rural, give location)

838 Harlem Ave

c. Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

1876

9. AGE (In years  
last birthday)

74

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Hairstresser

10b. KIND OF BUSINESS OR  
INDUSTRY

Self-employed

11. BIRTHPLACE (State or foreign country)

Neals Island, Md

12. CITIZEN OF  
WHAT COUNTRY?

?

13. FATHER'S NAME

William S. Shields

14. MOTHER'S MAIDEN NAME

Tannie W. Weaver

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Elizabeth Murray

ADDRESS

201 Mosher St.

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHI  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Auricular Fibrillation

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Ht. Disease

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Senility

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK22. I hereby certify that I attended the deceased from 10-3-, 1950, to 10-5-, 1950, that I last saw the  
deceased alive on 10-5-, 1950, and that death occurred at 1:40 A. M., from the causes and on the date stated above.

23A. SIGNATURE

J. A. Pinney

23B. ADDRESS

M. D.

Provident Hospital

23C. DATE SIGNED

10-5-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

DATE RECEIVED BY

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 15 1950

740FF

093d

correct age is especially important. Physicians, please write the cause of death clearly and legibly.



1. The first of these is the fact that the  
 2. second of these is the fact that the  
 3. third of these is the fact that the  
 4. fourth of these is the fact that the  
 5. fifth of these is the fact that the  
 6. sixth of these is the fact that the  
 7. seventh of these is the fact that the  
 8. eighth of these is the fact that the  
 9. ninth of these is the fact that the  
 10. tenth of these is the fact that the

1774/55



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 8577

BIRTH NO. 50-21203

1. NAME OF DECEASED  
(Type or Print)

**BABY FEMALE GREEN (NEO NATA DEATH)**

2. DATE OF DEATH

**OCTOBER 4, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address of location)

**MERCY HOSPITAL**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

STATE **MD.**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**BALTIMORE**

**27-12**

D. STREET ADDRESS (If rural, give location)

**5921 BELLEONA AVE**

c. Length of stay in Baltimore

**CHILD LIVED ONE HOUR**

Yrs. Mos. Days

5. SEX

**F**

6. COLOR OR RACE

**W**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

**10/4/50**

9. AGE (In years last birthday)

If Under 1 Year Months Days If Under 24 Hours Hours Min.

**1 0**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**BALTIMORE, MD.**

12. CITIZEN OF WHAT COUNTRY?

**USA**

13. FATHER'S NAME

**PAUL JOSEPH GREEN**

14. MOTHER'S MAIDEN NAME

**JEAN MORRISSEY**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**NO**

16. SOCIAL SECURITY NO.

17. INFORMANT

**MOTHER**

ADDRESS

**SAME**

18. **761.0**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **CEREBRAL ANOXIA**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **CONSTRICTION OF CORD**

DUE TO

(C)

**NOT**

**KNOWN**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

**None**

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **2 AM 10/4, 19 50**, to **3 AM 10/4, 19 50**, that I last saw the deceased alive on **10/4, 19 50**, and that death occurred at **3 A** m., from the causes and on the date stated above.

23A. SIGNATURE

**John A Ferris**

M. D.

23B. ADDRESS

**Mercy Hosp.**

23C. DATE SIGNED

**10/4/50**

24A. BURIAL, CREMATION, REMOVALS (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**CT - 61950**

**Oct 5/1950**

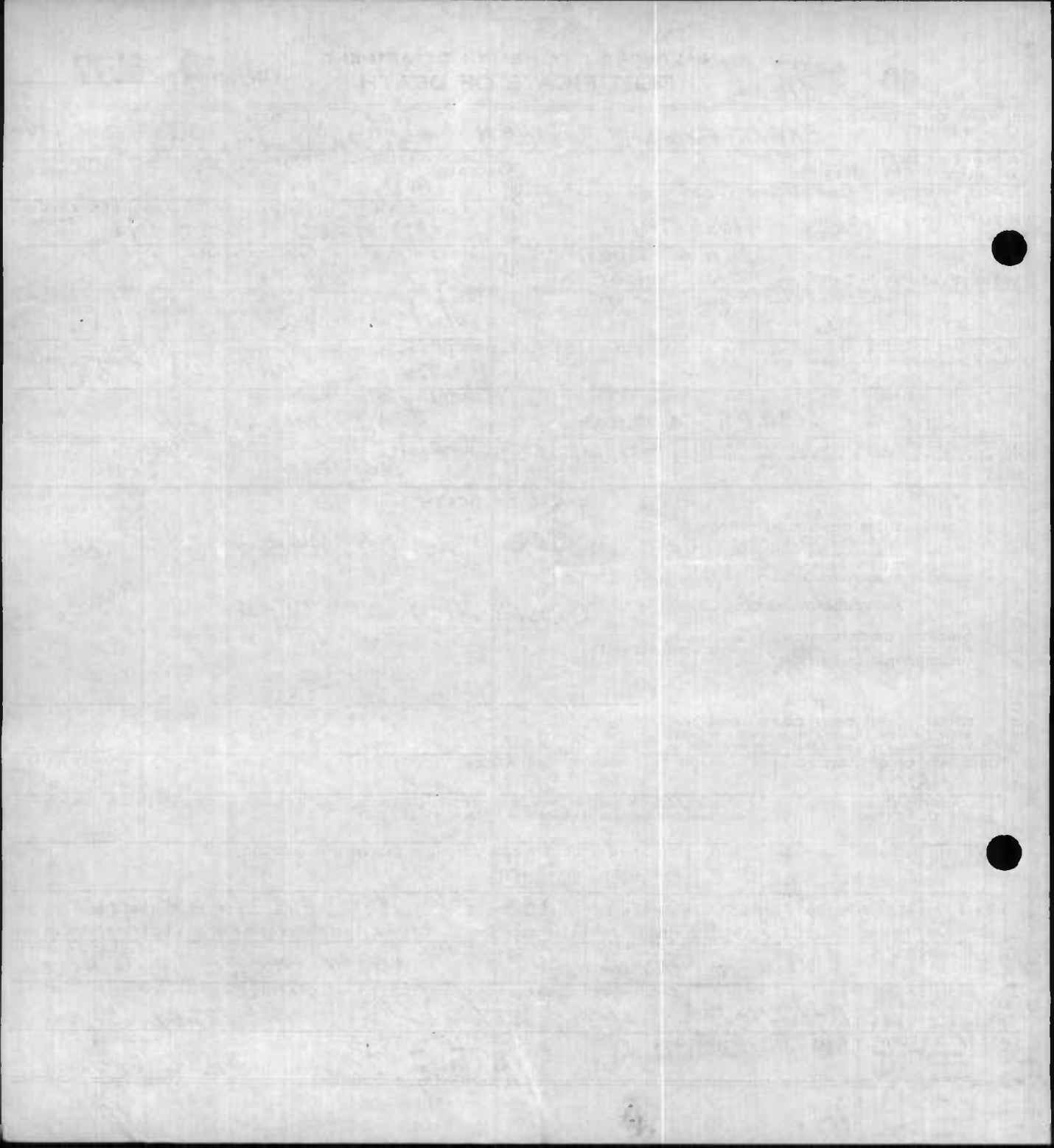
**New Cathedral**

**Baltimore Md.**

**8577/Thimaco 4204 Ridgewood**

correct age is especially important. In parentheses, please write the date of death clearly and legibly.

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**HARRY MORGAN**

2. DATE  
OF  
DEATH

**Oct 6, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

**OSL 61**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**JOHNS HOPKINS HOSPITAL**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

**MARYLAND**

B. COUNTY

C. CITY OR TOWN

**BALTIMORE**

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

**4711 PARK HEIGHTS AVE.**

c. Length of stay in Baltimore

5. SEX

**MALE**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**MARRIED**

8. DATE OF BIRTH

**4-12-83**

9. AGE (In years last birthday)

**67**

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**INVESTIGATOR**

10B. KIND OF BUSINESS OR COMMERCIAL INDUSTRY

**OF MOTOR VEHICLES**

11. BIRTHPLACE (State or foreign country)

**Virginia**

12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**Benjamin Morgan**

14. MOTHER'S MAIDEN NAME

**Mary A. Gressitt**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**YES**

**Spanish American**

16. SOCIAL SECURITY NO.

**none**

17. INFORMATION

**JOHNS HOPKINS HOSPITAL**

ADDRESS

18. **163X**

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A)

**Squamous Cell**

DUE TO

(B)

**Carcinoma of Right Lung**

DUE TO

(C)

**1-2 yrs**

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **10-3**, 19**50**, to **10-6**, 19**50**, that I last saw the deceased alive on **10-6**, 19**50**, and that death occurred at **12:00 a.m.**, from the causes and on the date stated above.

23A. SIGNATURE

**David Jenkins**

M. D.

23B. ADDRESS

**JOHNS HOPKINS HOSPITAL**

23C. DATE SIGNED

**10-6-50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**burial**

24B. DATE

**10/9/50**

24C. NAME OF CEMETERY OR CREMATORY

**Baltimore National**

24D. LOCATION (City, town, or county)

**Baltimore, Md.**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

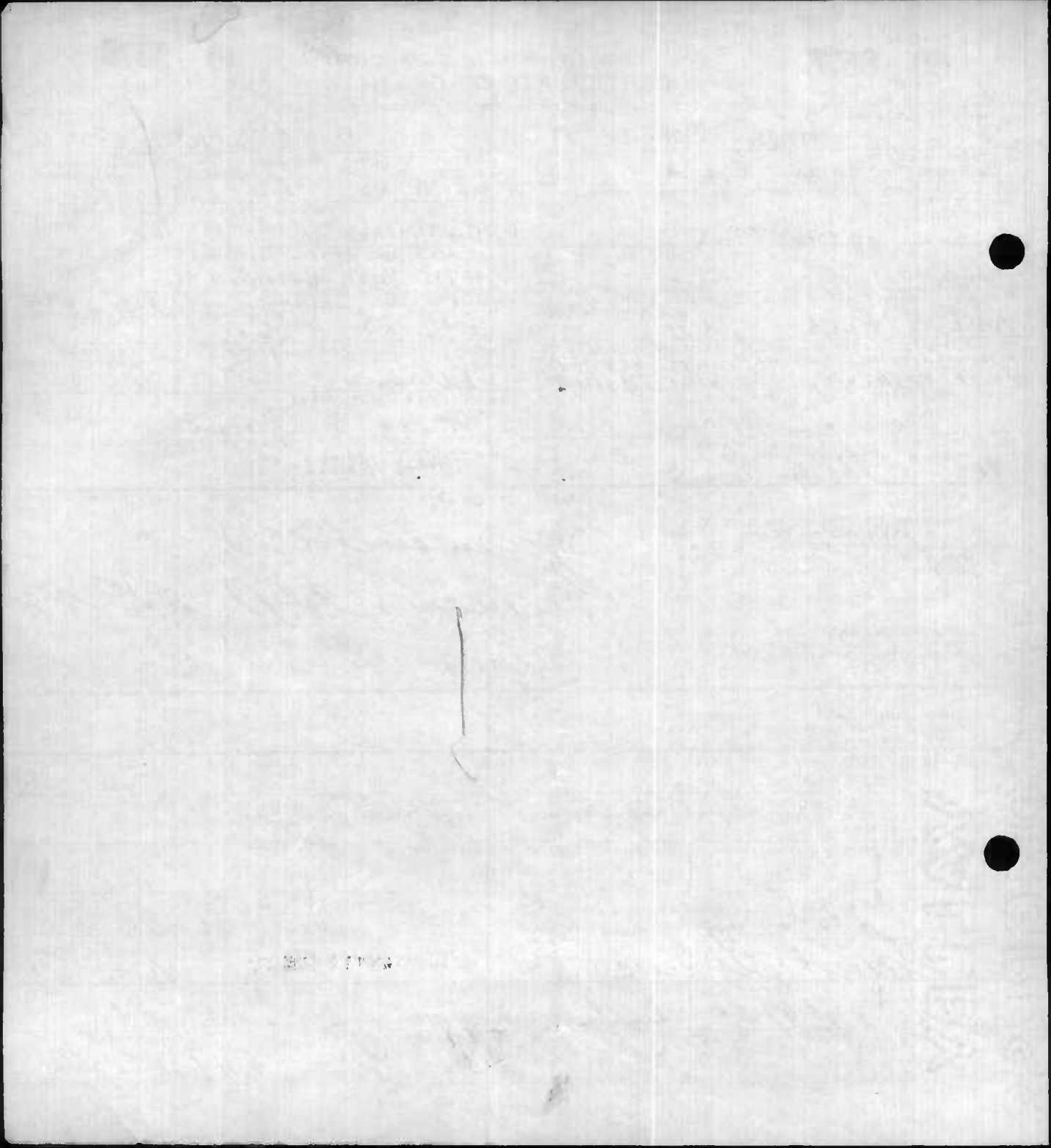
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**William Williams**

**B. Vernon Lemon, 4611 Park Heights**



F-630

50 8579

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8579

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CORTES FENTON FORD, JR.</b>			2. DATE OF DEATH <b>Oct. 5, 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>D.C.</b> B. COUNTY <b>V-48</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR <b>US Marine Hospital</b> INSTITUTION <b>Wyman Pk. Drive &amp; 31st St.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Washington</b>		
c. Length of stay in Baltimore <b>11 days</b>			D. STREET ADDRESS (If rural, give location) <b>1515 -33rd St. NW</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>4/12/24</b>	9. AGE (In years last birthday) <b>26</b>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired) <b>Student</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Oregon</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>C. Fenton Ford, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Harriet Wells</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or of unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>544-14-5498</b>	17. INFORMANT ADDRESS <b>Records- US Marine Hospital, Balto, Md.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or of unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>544-14-5498</b>	17. INFORMANT ADDRESS <b>Records- US Marine Hospital, Balto, Md.</b>		

18. <b>197x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hemangioendothelioma, primary left chest wall with metastasis to lungs, pleura and skull.</b>	CAUSE OF DEATH <b>Hemangioendothelioma, primary left chest wall with metastasis to lungs, pleura and skull.</b>	INTERVAL BETWEEN ONSET AND DEATH <b>More than 2 yrs.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(A) DUE TO	
	(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION <b>10/2/50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>Sept. 24, 1950</b> , to <b>Oct. 5, 1950</b> , that I last saw the deceased alive on <b>Oct. 5, 1950</b> , and that death occurred at <b>10:35 P.m.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>John L. Wilson, Medical Director</b>	23B. ADDRESS <b>US Marine Hospital, Balto, Md.</b>	23C. DATE SIGNED <b>10/6/50</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	24B. DATE <b>10/2/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>	24D. LOCATION (City, town, or county) (State) <b>Bladensburg, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>William J. Williams</b>	25. FUNERAL DIRECTOR <b>Wm. J. Tiekner &amp; Sons, Balto. Md.</b>		

OCT VS 15050

056e

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

NO. 100-100000

TO : DIRECTOR, FBI (100-100000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

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94. [Illegible]

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96. [Illegible]

97. [Illegible]

98. [Illegible]

99. [Illegible]

100. [Illegible]



5-352  
50 5580BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

OLIVER STONESIFER

2. DATE  
OF  
DEATH

10-6-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

University Hospital

c. Length of stay in Baltimore

6

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

MARYLAND

B. COUNTY

CARROLL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Union Bridge

D. STREET ADDRESS (If rural, give location)

Broadway

5600

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE (MARRIED)

WIDOWED, DIVORCED, (Specify)

10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired)

Operator Printing Shop

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

1868

9. AGE (In years last birthday)

82

11 Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY?

U. S.

14. MOTHER'S MAIDEN NAME

not known

17. INFORMANT

ADDRESS

Walter H. Hinkle, Union Bridge, Md.

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

15 days

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis, generalized

unknown

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Oct 4, 1950, to Oct. 6, 1950, that I last saw the deceased alive on Oct. 6, 1950, and that death occurred at 4:20 m., from the causes and on the date stated above.

23A. SIGNATURE

Robert T. Parher

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

Oct. 6, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

10-9-50

24C. NAME OF CEMETERY OR CREMATORY

Guthrie Center, Annapolis, Md.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Walter H. Hinkle, Jr.

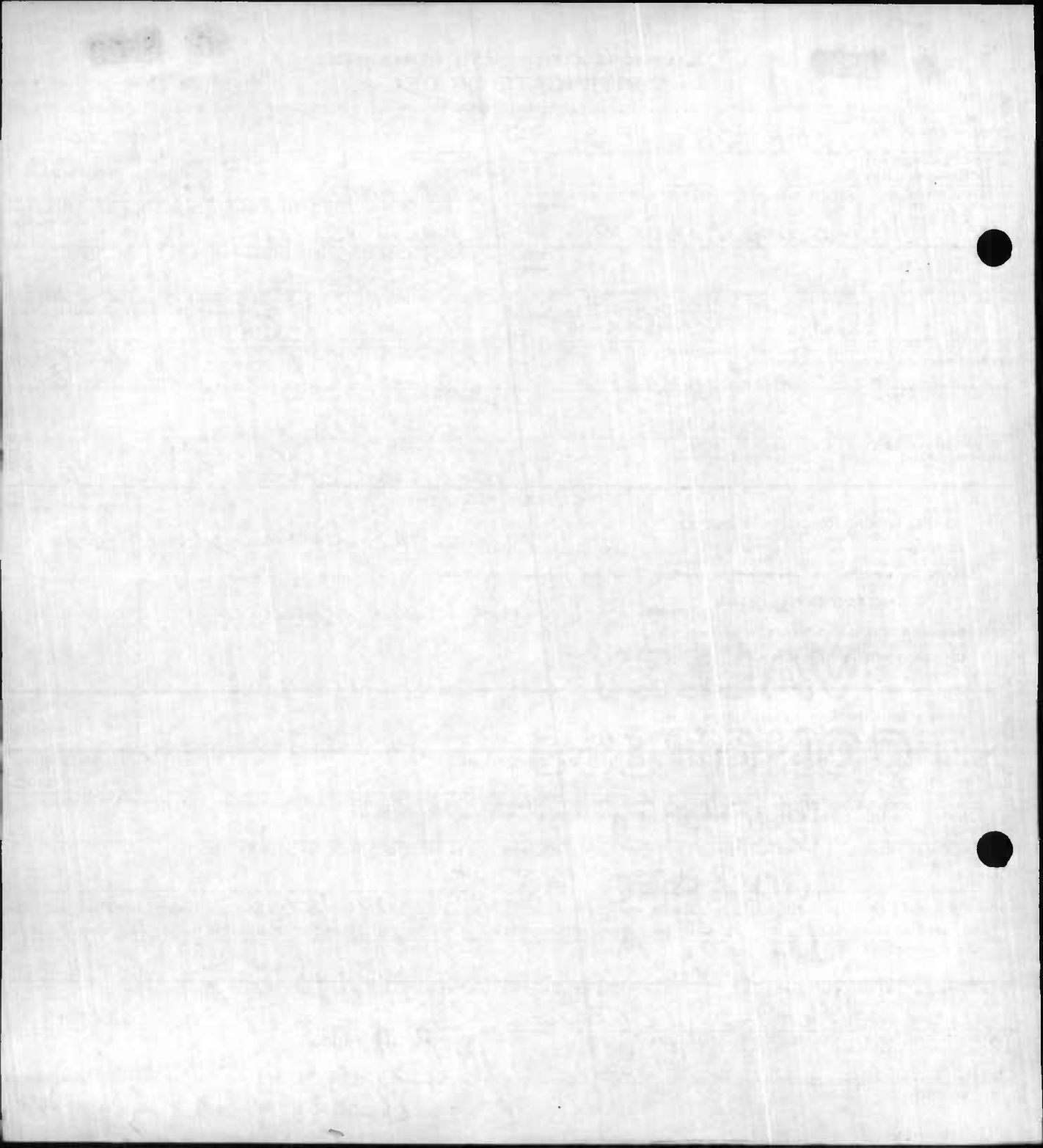
25. FUNERAL DIRECTOR

ADDRESS

1001 H. H. Hinkle, Union Bridge, Md.

OCT-7-1950

VS 150



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Debbie*

**LAMBERT**

2. DATE  
OF  
DEATH

**10-6-50**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION **MARYLAND GENERAL HOSPITAL**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **MARYLAND** B. COUNTY **harroll**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**WESTMINSTER** **5641**

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

**2**

Tues.  
Mos.  
Days

5. SEX

**F**

6. COLOR OR RACE

**W**

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

**MARRIED**

8. DATE OF BIRTH

**OCT 25, 1871**

9. AGE (In years  
last birthday)

**78**

If Under 1 Year  
Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR  
INDUSTRY

*Home*

11. BIRTHPLACE (State or foreign country)

**MARYLAND**

12. CITIZEN OF  
WHAT COUNTRY?

**U.S.A**

13. FATHER'S NAME

**EZRA WANTZ**

14. MOTHER'S MAIDEN NAME

**BELINDA BROWN**

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

**DECEASED**

ADDRESS

18. **260x**

**CAUSE OF DEATH**

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) **Cerebral Thrombosis**  
DUE TO **with bronchopneumonia**

**20 days**  
**5 days**

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_  
DUE TO \_\_\_\_\_  
(C) **Diabetes mellitus**

**10 yrs**

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

**Gangrene of left foot (amputated  
8-15-50)**

19A. DATE OF OPERATION

**8-15-50**

19B. MAJOR FINDINGS OF OPERATION

**Gangrene of left foot**

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **8-7**, 19**50**, to **10-6**, 19**50**, that I last saw the  
deceased alive on **10-6**, 19**50** and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23A. SIGNATURE

*Paul G. Harold*

M. D.

23B. ADDRESS

*Maryland General Hosp.*

23C. DATE SIGNED

**10-6-50**

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

**Oct. 12, 1950**

24C. NAME OF CEMETERY OR CREMATORY

**Knickerbocker Cemetery**

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**10-1-1950**

25. FUNERAL DIRECTOR

*David A. Boydland*

ADDRESS

1922

1922

1922

1922

1922

1922

1922

1922

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B-6020582 **CERTIFICATE CORRECTED** 5-15-50 50 8582  
BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH** Registered No. \_\_\_\_\_

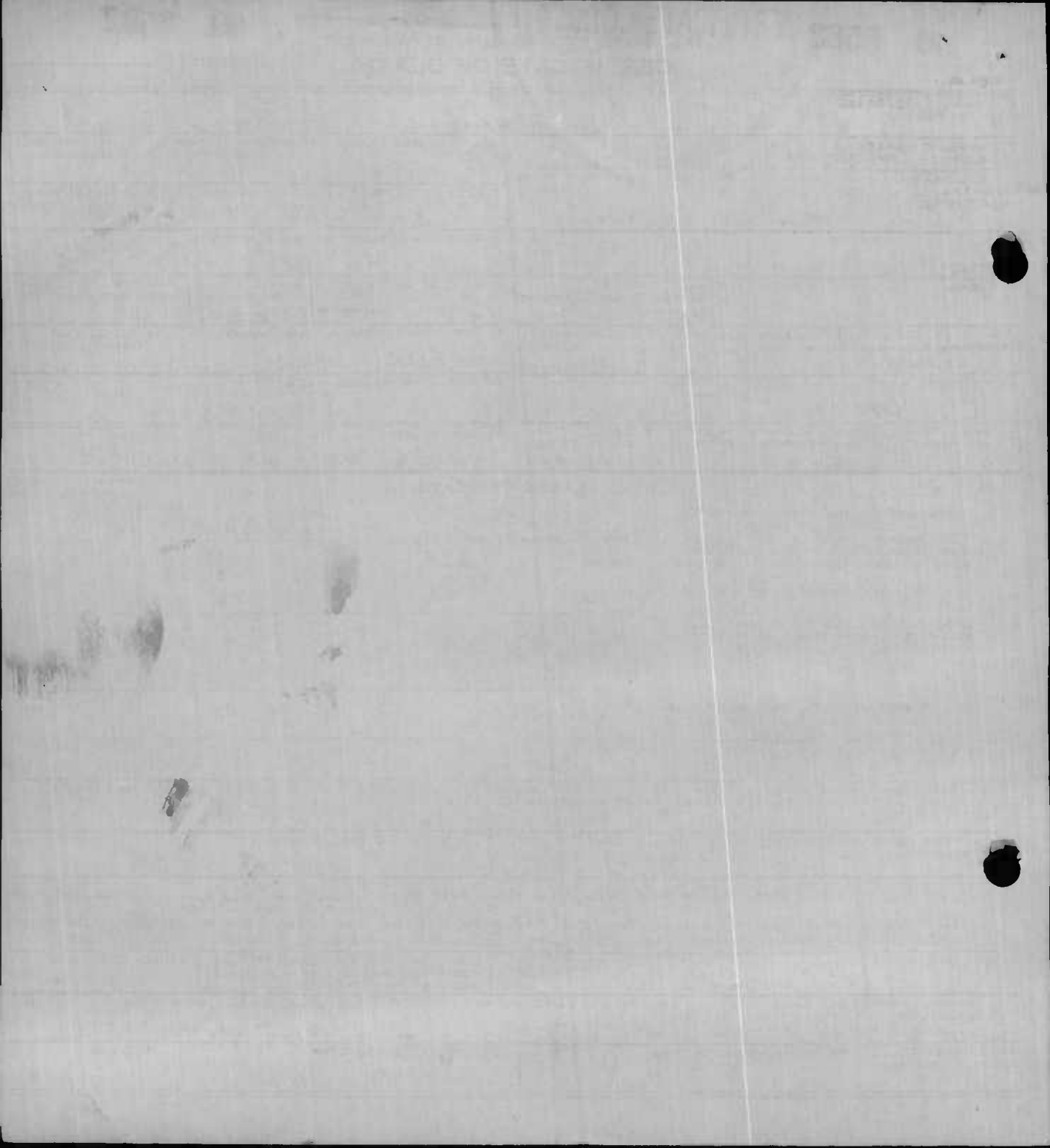
BIRTH NO \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>William Lee Burke</i>		2. DATE OF DEATH <i>10/6/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore MD 20-01</i>	
D. STREET ADDRESS (If rural, give location) <i>2236 W. BALTO ST</i>		E. LENGTH OF STAY IN BALTIMORE <i>LIFE</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>1883</i> <i>Feb. 9, 1888</i>
10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <i>Custodian</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>City Schools</i>	
13. FATHER'S NAME <i>William T. Burke</i>		14. MOTHER'S MAIDEN NAME <i>ELLA NORWOOD</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO NONE</i>		16. SOCIAL SECURITY NO. <i>215-09-2401</i>	
17. INFORMANT <i>MARY S. BURKE</i>		ADDRESS <i>2236 W. BALTO. ST.</i>	

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>II</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>[Signature]</i>	23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.	23C. DATE SIGNED <i>10/6/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>10-10-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>WESTERN</i>
24D. LOCATION (City, town, or county) <i>BALTIMORE MD.</i>	25. FUNERAL DIRECTOR <i>GEO. L. Schwab</i>	ADDRESS <i>2101 FREDERICK AVE</i>





# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

LILLIAN May BROOKS

2. DATE  
OF  
DEATH

October 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

8. FULL NAME OF (If not in hospital or institution, give street address or location)

Franklin Square Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1906 Wilhelm Street

Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

JUNE 12, 1943

9. AGE (In years last birthday)

7

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WALTER M. BROOKS

14. MOTHER'S MAIDEN NAME

Anna M. Scherer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

NO

NONE

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

ADDRESS

WALTER BROOKS 1906 WILHELM ST.

18. E 812.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rupture of liver

30228

ANTECEDENT CAUSES

(B) Intraperitoneal hemorrhage

30228

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Multiple contusions and abrasions

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Pratt Street near Payson Street 20-3

21D. TIME (Month) (Day) (Year) (Hour)

October 5, 1950 8:00A.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Struck by an automobile

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William L. Scher

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

23C. DATE SIGNED

October 6, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

10-9-50

24C. NAME OF CEMETERY OR CREMATORY

Meadowridge

24D. LOCATION (City, town, or county)

Howard County Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT - 7 1950

Funeral Home

Geo. L. Schwab 2101 Frederick Ave

VS 151

N 864.2

170C

MEDICAL CERTIFICATION

MINISTRE DU SANTE  
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

TO BE FILLED BY THE REGISTRAR

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R-300

50 8584

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) (FRANK REED) FRANCIS REID			2. DATE OF DEATH October 4, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		
B. FULL NAME OF (If not in hospital or institution, give street address or location) Provident Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-02		
D. STREET ADDRESS (If rural, give location) 1115 Whatcoat Street			E. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____		
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Sept 15	9. AGE (In years last birthday) 78	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Reed			14. MOTHER'S MAIDEN NAME Mary Reed		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Dr. Panam Reed		

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....☐ 23C. DATE SIGNED  
M.D. ASSISTANT MEDICAL EXAMINER.....☒ Oct. 4, 1950  
MEDICAL INVESTIGATOR.....☐

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of church	
17. Signature of school		18. Signature of hospital		19. Signature of nursing home		20. Signature of other institution	
21. Signature of other institution		22. Signature of other institution		23. Signature of other institution		24. Signature of other institution	
25. Signature of other institution		26. Signature of other institution		27. Signature of other institution		28. Signature of other institution	
29. Signature of other institution		30. Signature of other institution		31. Signature of other institution		32. Signature of other institution	
33. Signature of other institution		34. Signature of other institution		35. Signature of other institution		36. Signature of other institution	
37. Signature of other institution		38. Signature of other institution		39. Signature of other institution		40. Signature of other institution	
41. Signature of other institution		42. Signature of other institution		43. Signature of other institution		44. Signature of other institution	
45. Signature of other institution		46. Signature of other institution		47. Signature of other institution		48. Signature of other institution	
49. Signature of other institution		50. Signature of other institution		51. Signature of other institution		52. Signature of other institution	
53. Signature of other institution		54. Signature of other institution		55. Signature of other institution		56. Signature of other institution	
57. Signature of other institution		58. Signature of other institution		59. Signature of other institution		60. Signature of other institution	
61. Signature of other institution		62. Signature of other institution		63. Signature of other institution		64. Signature of other institution	
65. Signature of other institution		66. Signature of other institution		67. Signature of other institution		68. Signature of other institution	
69. Signature of other institution		70. Signature of other institution		71. Signature of other institution		72. Signature of other institution	
73. Signature of other institution		74. Signature of other institution		75. Signature of other institution		76. Signature of other institution	
77. Signature of other institution		78. Signature of other institution		79. Signature of other institution		80. Signature of other institution	
81. Signature of other institution		82. Signature of other institution		83. Signature of other institution		84. Signature of other institution	
85. Signature of other institution		86. Signature of other institution		87. Signature of other institution		88. Signature of other institution	
89. Signature of other institution		90. Signature of other institution		91. Signature of other institution		92. Signature of other institution	
93. Signature of other institution		94. Signature of other institution		95. Signature of other institution		96. Signature of other institution	
97. Signature of other institution		98. Signature of other institution		99. Signature of other institution		100. Signature of other institution	

P-236

8585

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50

8585

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary Pusateri

2. DATE  
OF  
DEATH

Oct. 4, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland 3406 Harford Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Baltimore, Maryland

B. COUNTY

before admission)

b. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

c. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

d. STREET ADDRESS (If rural, give location)

3406 Harford Road

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

May 21, 1873

9. AGE (In years,  
last birthday)

77

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Tunis, Africa

12. CITIZEN OF  
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Anthony Pace

14. MOTHER'S MAIDEN NAME

Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Albert Pusateri 3406 Harford Road

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, assthonia, etc. It means the disease,  
injury or complication which caused death.)(A) ...  
DUE TO

Acute Coriary Failure

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) ...  
DUE TO

Cory Sclerosis

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) ...

Ch Myocarditis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from 7/5, 1950, to Sept 3, 1950, that I last saw the  
deceased alive on Sept 3, 1950, and that death occurred at 8:4 p.m., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

M. D.

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

Burial

Oct. 7, 1950

Holy Redeemer

Baltimore

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S

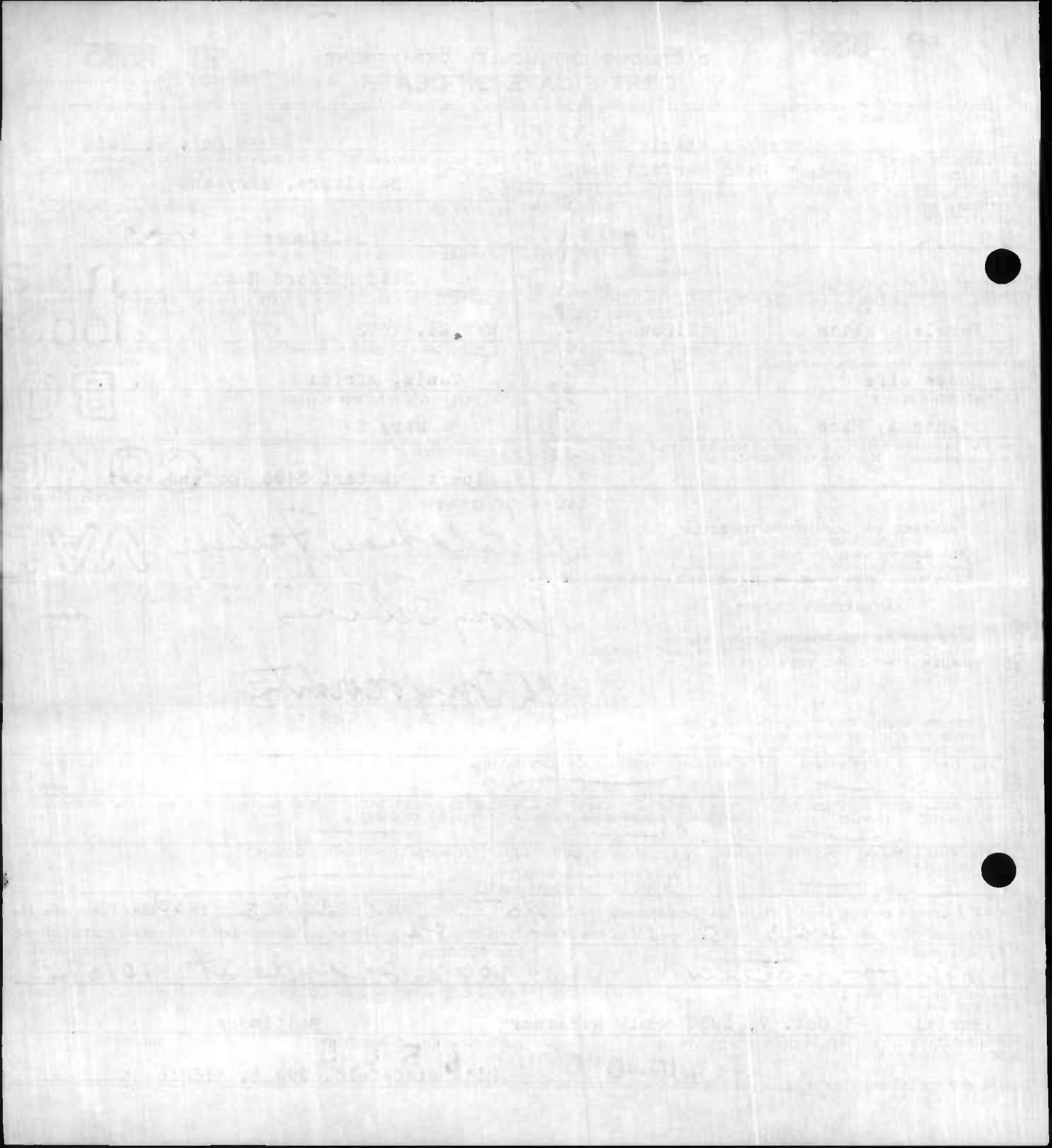
ADDRESS

OCT 7 1950

Rita Wiedefeld, 900 E. Biddle St

093 d

MEDICAL CERTIFICATION





H-560

50 8586

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8586

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Henry P. J. Heummes

2. DATE  
OF  
DEATHOct 5<sup>th</sup> 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1927 N Patterson Park

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto

8-02

C. LENGTH OF STAY IN BALTIMORE

Life

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

1927 N Patterson Park Ave

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug 16<sup>th</sup> 18889. AGE (In years  
last birthday)

62

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Young's Seldon

10B. KIND OF BUSINESS OR  
INDUSTRY

Printer's Foreman

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

John J. Heummes

14. MOTHER'S MAIDEN NAME

Dorothy Ulman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

(Yes, no or unknown)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Antonetta Heummes 1927 Patterson

18. 442X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebral Thrombosis

1 WK

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Cardio-renal-vascular  
Disease with Hypertension

5 years

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from May 21, 1945, to Oct. 5, 1950, that I last saw the  
deceased alive on Oct. 5, 1950 and that death occurred at 10:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Burial

Oct 9<sup>th</sup> 1950

Holy Redeemer

Belair Road

VS 150

CT-71950

523 414

131a

Lester S. Leach 1701-03 N. Patterson Park Ave

2623 E. Mon Wz Joska  
or 8 203

H-520

50 8587

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

AGNES A. HAYNES

2. DATE

OF

DEATH 10/4/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1707 Jackson St.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

00

Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1707 Jackson St.

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

7/25/1874

9. AGE (In years  
last birthday)

76

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Family - Same

18. 420.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arterio sclerotic heart disease.  
DUE TO chronic nephritis.About  
six mos.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) General arterio sclerosis.

?

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 15, 1950 to Oct. 4, 1950, that I last saw the  
deceased alive on 10/3/50 and that death occurred at 1 A.m., from the causes and on the date stated above.

23A. SIGNATURE

Harry Deibel

M. D.

23B. ADDRESS

1226 Hanover Street,

23C. DATE SIGNED

10/5/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

B

24B. DATE

10/7/50

24C. NAME OF CEMETERY OR CREMATORY

Montgomery Chapel

24D. LOCATION (City, town, or county)

Montgomery Co. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

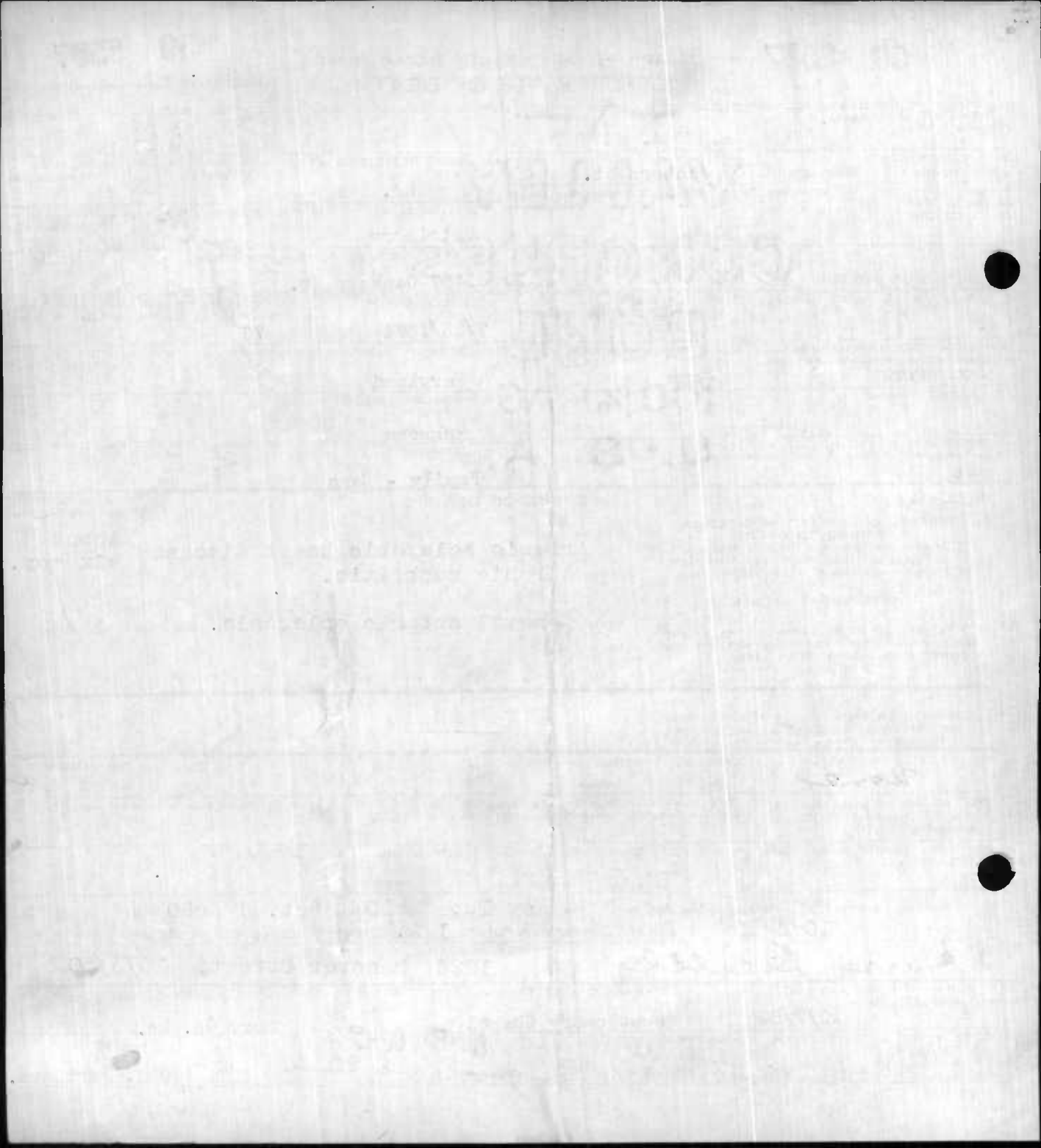
ADDRESS

OCT - 7/1950

Montgomery Williams, Me

James L. Deibel

\* 130 E. Fort Ave.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

JAMES THOMAS BURNS, SR.

2. DATE  
OF  
DEATH

October 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

2014 Walbrook Avenue

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Widowed

8. DATE OF BIRTH

Dec. 9, 1902

9. AGE (In years  
last birthday)

47

If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Manager

10B. KIND OF BUSINESS OR INDUSTRY

Gas station

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Burns

14. MOTHER'S MAIDEN NAME

Mary Feeley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

St.

Mr. James T. Burns, Jr., 1606 N. Smallwood

18.

**CAUSE OF DEATH**

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar pneumonia, right middle lobe

**ANTECEDENT CAUSES**

(B) Fatty infiltration of liver

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*William V. Lovick*

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

October 6, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
Burial

24B. DATE

10/9/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

OCT - 7 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Wm. J. Dickner & Sons - Balto.*

MEDICAL CERTIFICATION

1955

MINNESOTA CIVIL SERVICE COMMISSION

CERTIFICATE OF DEATH

1. Name of deceased		2. Date of death	
3. Place of death		4. Cause of death	
5. Age at death		6. Sex	
7. Marital status		8. Occupation	
9. Date of birth		10. Date of death	
11. Signature of physician		12. Signature of registrar	
13. Signature of funeral director		14. Signature of next of kin	
15. Signature of coroner		16. Signature of justice of the peace	
17. Signature of health officer		18. Signature of medical examiner	
19. Signature of pathologist		20. Signature of toxicologist	
21. Signature of forensic anthropologist		22. Signature of forensic odontologist	
23. Signature of forensic psychologist		24. Signature of forensic psychiatrist	
25. Signature of forensic linguist		26. Signature of forensic artist	
27. Signature of forensic photographer		28. Signature of forensic scientist	
29. Signature of forensic chemist		30. Signature of forensic biologist	
31. Signature of forensic geologist		32. Signature of forensic meteorologist	
33. Signature of forensic astronomer		34. Signature of forensic physicist	
35. Signature of forensic mathematician		36. Signature of forensic statistician	
37. Signature of forensic economist		38. Signature of forensic sociologist	
39. Signature of forensic anthropologist		40. Signature of forensic archaeologist	
41. Signature of forensic historian		42. Signature of forensic linguist	
43. Signature of forensic psychologist		44. Signature of forensic psychiatrist	
45. Signature of forensic linguist		46. Signature of forensic artist	
47. Signature of forensic photographer		48. Signature of forensic scientist	
49. Signature of forensic chemist		50. Signature of forensic biologist	
51. Signature of forensic geologist		52. Signature of forensic meteorologist	
53. Signature of forensic astronomer		54. Signature of forensic physicist	
55. Signature of forensic mathematician		56. Signature of forensic statistician	
57. Signature of forensic economist		58. Signature of forensic sociologist	
59. Signature of forensic anthropologist		60. Signature of forensic archaeologist	
61. Signature of forensic historian		62. Signature of forensic linguist	
63. Signature of forensic psychologist		64. Signature of forensic psychiatrist	
65. Signature of forensic linguist		66. Signature of forensic artist	
67. Signature of forensic photographer		68. Signature of forensic scientist	
69. Signature of forensic chemist		70. Signature of forensic biologist	
71. Signature of forensic geologist		72. Signature of forensic meteorologist	
73. Signature of forensic astronomer		74. Signature of forensic physicist	
75. Signature of forensic mathematician		76. Signature of forensic statistician	
77. Signature of forensic economist		78. Signature of forensic sociologist	
79. Signature of forensic anthropologist		80. Signature of forensic archaeologist	
81. Signature of forensic historian		82. Signature of forensic linguist	
83. Signature of forensic psychologist		84. Signature of forensic psychiatrist	
85. Signature of forensic linguist		86. Signature of forensic artist	
87. Signature of forensic photographer		88. Signature of forensic scientist	
89. Signature of forensic chemist		90. Signature of forensic biologist	
91. Signature of forensic geologist		92. Signature of forensic meteorologist	
93. Signature of forensic astronomer		94. Signature of forensic physicist	
95. Signature of forensic mathematician		96. Signature of forensic statistician	
97. Signature of forensic economist		98. Signature of forensic sociologist	
99. Signature of forensic anthropologist		100. Signature of forensic archaeologist	



M-253

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 8589

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARGUERITE McKINDLESS

2. DATE OF DEATH  
Oct. 5, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Ashburton Nursing Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4608 Marble Hall Rd.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Nov. 22, 1872

9. AGE (In years, last birthday)

77

If Under 1 Year Months Days  
If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

August Derlin

14. MOTHER'S MAIDEN NAME

Marguerite Polletty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Derlin G. McKindless-4608 Marble Hall Rd.

18. 450.0

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from

1944 to

Oct. 5, 1950

that I last saw the deceased alive on Sept. 1, 1950 and that death occurred at 11A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

10/9/50

Green Mount Cem.

Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

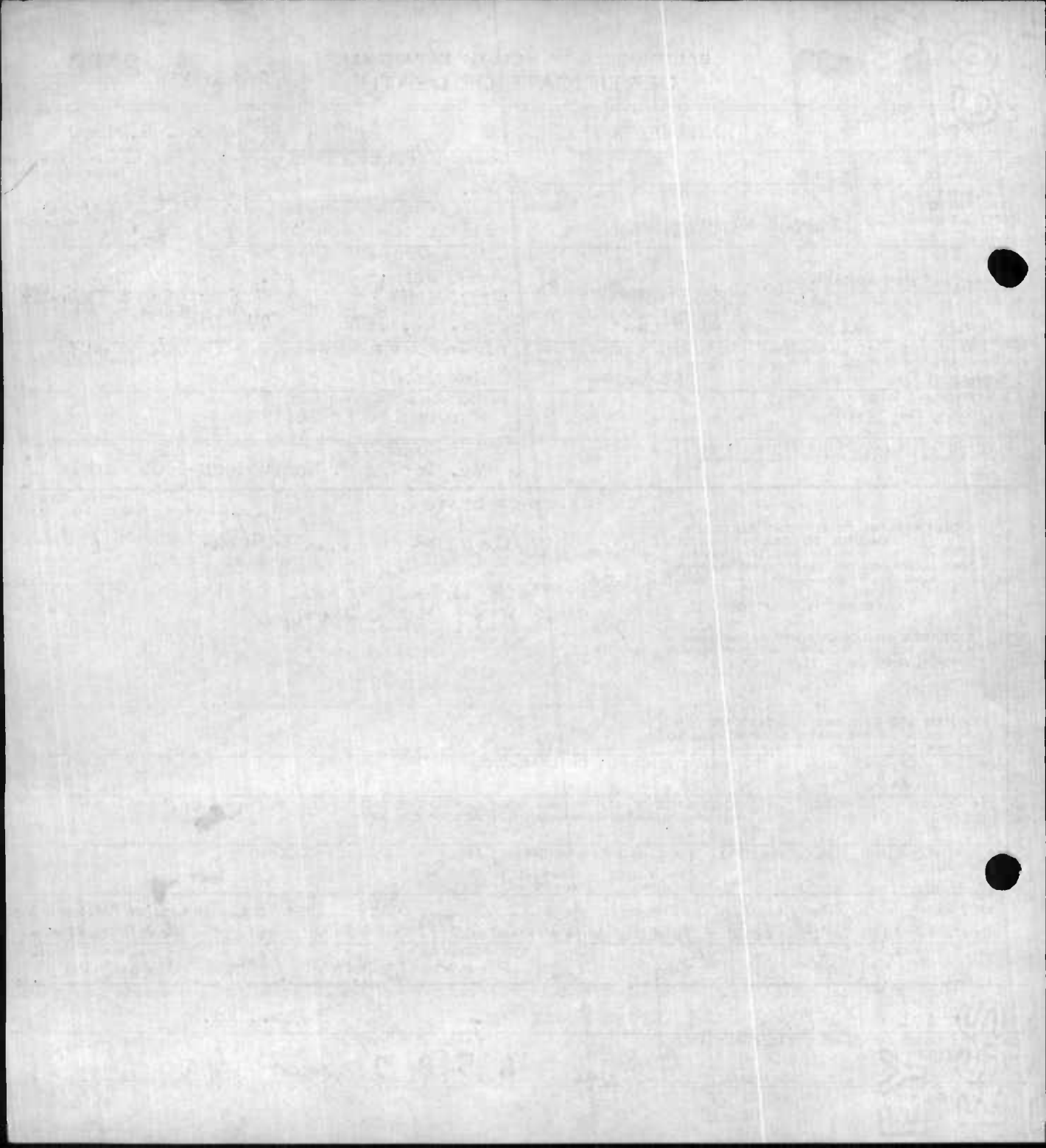
25. FUNERAL DIRECTOR

ADDRESS

OCT-7-1950

5-14-1950  
 8/5/50  
 097.0

MEDICAL CERTIFICATION



C-656  
Rea 141853BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Laurene Cromartie

2. DATE  
OF  
DEATH

10-3-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2419 Stockton Street

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

Yrs.  
Mos.  
Days

8. DATE OF BIRTH

Jan. 2, 1923

9. AGE (In years

last birthday)

27

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Waterboro, S.E.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Herman Turner

14. MOTHER'S MAIDEN NAME

Laura Grant

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS 4940

Records\* Balto. City Hospitals Eastern Ave

18. 010X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculous Meningoencephalitis

DUE TO

4 Mos.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-21, 1950 to 10-3, 1950, that I last saw the deceased alive on 10-3, 1950, and that death occurred at 4:15 P.M. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

10-6-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 7, 1950

24C. NAME OF CEMETERY OR CREMATORY

Live Oak

24D. LOCATION (City, town, or county)

Waterboro, S.C.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

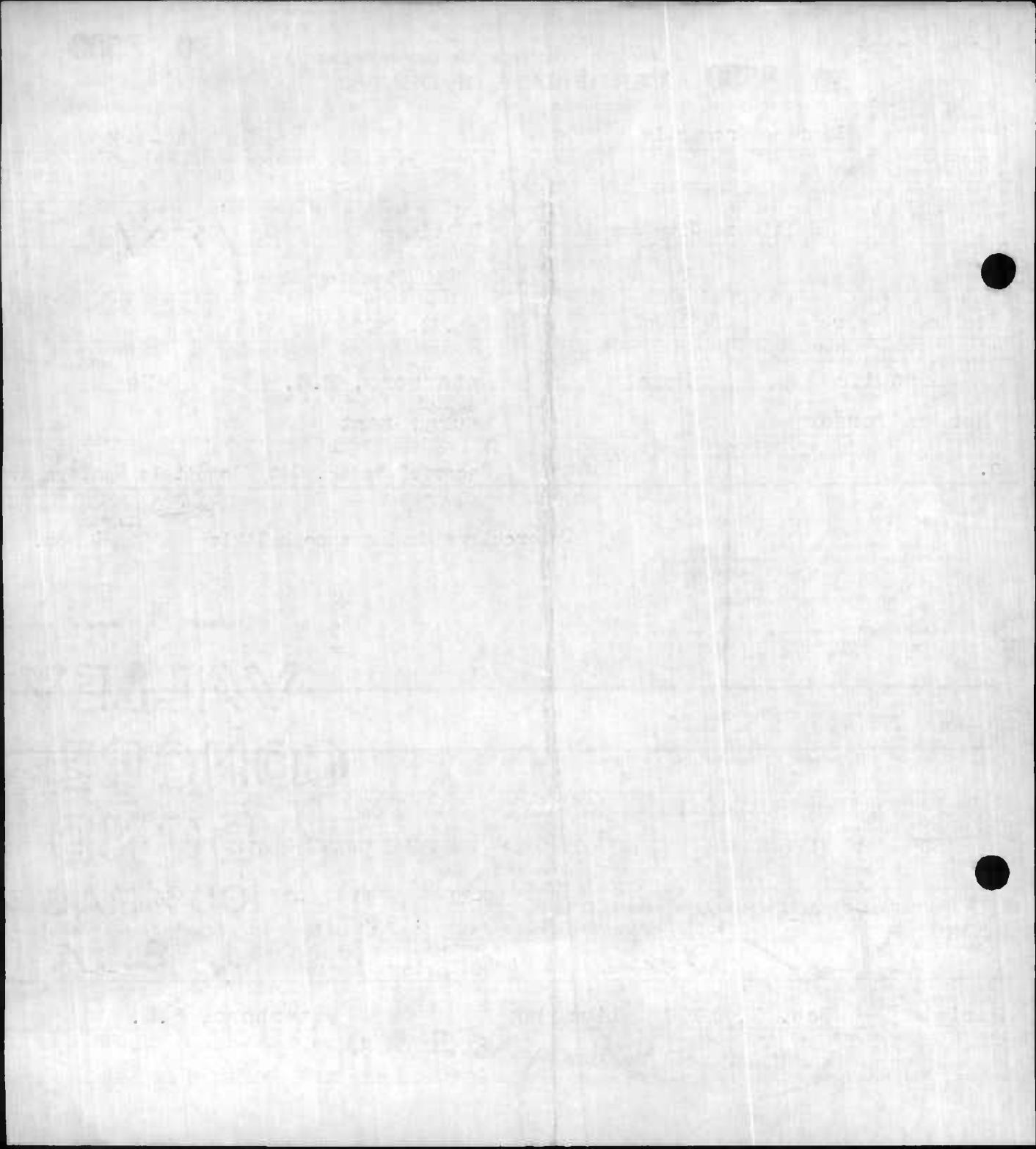
25. FUNERAL DIRECTOR

ADDRESS

OCT - 7 1950

VS 150

014.0



D-200  
50 8591BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8591

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

KATHLEEN

DIGGS

2. DATE  
OF DEATH October 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

D. O. A. PROVIDENT HOSPITAL

Yrs.  
Mos.  
Days

Length of stay in Baltimore

12 YRS.

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

1-9-05

9. AGE (In years  
last birthday)

45

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

DOMESTIC

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

PAUL GWALTNEY - 2307 PENNA. AVE..

18. 002X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary tuberculosis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. Smith

23B. CHIEF MEDICAL EXAMINER.....☒

23C. DATE SIGNED

M.D.

ASSISTANT MEDICAL EXAMINER.....☒

10-2-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

10-7-50

24C. NAME OF CEMETERY OR CREMATORY

MT. AUBURN

24D. LOCATION (City, town, or county)

BALTIMORE 30.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

71950

25. FUNERAL DIRECTOR

ADDRESS

Wm. A. JACKSON - 916 PENNA. AVE.

VS 151

720FA

0136

1052

01

HYACINTH STATE

1052

01



R-163

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print) *Miss Mary Ruppert*2. DATE  
OF  
DEATH *October 6, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *615 Dukeland*

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE *Maryland*

B. COUNTY \_\_\_\_\_

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)  
*Baltimore*

D. STREET ADDRESS (If rural, give location)

*615 Dukeland Street*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*female*

6. COLOR OR RACE

*white*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
*single*

8. DATE OF BIRTH

*May 13, 1871*9. AGE (In years  
last birthday)*79*If Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)*Ret. Seamstress*10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Maryland*12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

*John Ruppert*

14. MOTHER'S MAIDEN NAME

*Mary Weber*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
*none*

17. INFORMANT

ADDRESS

*Mrs. Agnes Buehler, 615 Dukeland Street*18. *422.1* *E 900.0* CAUSE OF DEATHINTERVAL BETWEEN  
ONSET AND DEATH*1 year*DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) \_\_\_\_\_  
DUE TO*Fracture left hip*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TOper: *R. K. Kishner* M. D.  
CHIEF OR ASST. MEDICAL EXAMINER,

(C) \_\_\_\_\_

*Arteriosclerotic CVD*

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

*Oct 4 1949*

19B. MAJOR FINDINGS OF OPERATION

*Fracture left hip.*

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)*Accident*21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)*Home*21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

*615 Dukeland*21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY*Oct. 3 1949 2:00 p.m.*

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

*Fell down cellar steps.*22. I hereby certify that I attended the deceased from *Oct 3, 1949* to *Oct*, 1950, that I last saw the  
deceased alive on *Aug*, 1950, and that death occurred at *7:30 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Charles A. Dwyer*

M. D.

23B. ADDRESS

*2950 Edmonds Ave*

23C. DATE SIGNED

*Oct 6 1950*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)*burial*

24B. DATE

*10/9/50*

24C. NAME OF CEMETERY OR CREMATORY

*New Cathedral*

24D. LOCATION (City, town, or county)

*Baltimore,**Maryland*DATE RECEIVED BY  
LOCAL REGISTRAR*OCT - 7 1950*

REGISTRAR'S SIGNATURE

*Washington Hall*

25. FUNERAL DIRECTOR

*Wm. Book, Inc.*

ADDRESS

*1217 St. Paul Street*

To Be Approved by Medical Examiner

W-410

8593

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Frank J. Wolff

2. DATE  
OF  
DEATH

10/6/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Colonial Nursing Home

C. CITY OR TOWN

Balto 21-01

D. STREET ADDRESS (If rural, give location)

788 Washington Blvd

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

10/2/1882

9. AGE (In years last birthday)

68

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

Building

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Wolff

14. MOTHER'S MAIDEN NAME

Margaret McGee

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-09-5180

17. INFORMANT

Thomas Wolff Washington Blvd

## CAUSE OF DEATH

18. 443X

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral Hemorrhage

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Hypertensive Cerebrovascular Disease 5 years

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

3 days

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-24, 1960, to 10-6, 1960, that I last saw the deceased alive on 10-6, 1960, and that death occurred at 2:20 P. m., from the causes and on the date stated above.

23A. SIGNATURE

John B. Welch Jr.

M. D.

23B. ADDRESS

1227 Wark Blvd

23C. DATE SIGNED

10-7-52

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

10/9/50

24C. NAME OF CEMETERY OR CREMATORY

St. Peters

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT-7-1950

500

Wm. Bok Inc. 1217 St. Paul St

VS 150

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MEDICAL CERTIFICATION

THE UNIVERSITY OF CHICAGO

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*JEFFERSON W. COOK*

2. DATE OF DEATH

*10-5-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

*Maryland General*

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

*Maryland Anne Arundel*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Middleville 5200*

Length of stay in Baltimore

Yrs.  
Mos.  
Days

O. STREET ADDRESS (If rural, give location)

*Crain Highway - 5 mi. S. of Glen Burnie*

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Widower*

8. DATE OF BIRTH

*Sept. 6, 1872*

9. AGE (In years last birthday)

*78*

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Farmer*

10B. KIND OF BUSINESS OR INDUSTRY

*Own Farm*

11. BIRTH PLACE (State or foreign country)

*Maryland*

12. CITIZEN OF WHAT COUNTRY?

*USA*

13. FATHER'S NAME

*Jefferson Cook*

14. MOTHER'S MAIDEN NAME

*Emma Kinstid*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

*None*

17. INFORMANT

ADDRESS

*Mr. De Rimple Langston*

18. *587.0*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Acute hemorrhagic pancreatitis*

DUE TO

*48 hrs*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

*Chronic gastritis, Cholelithiasis, Arteriosclerosis, atherosclerosis*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *10-5-1950* to *10-5-1950* that I last saw the deceased alive on *10-5-1950* and that death occurred at *10:30* p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

*BURIAL*

*OCT-8, 1950*

*MT. CARMEL*

*PASADENA MOUNTAIN ROAD A.A.C. MD*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

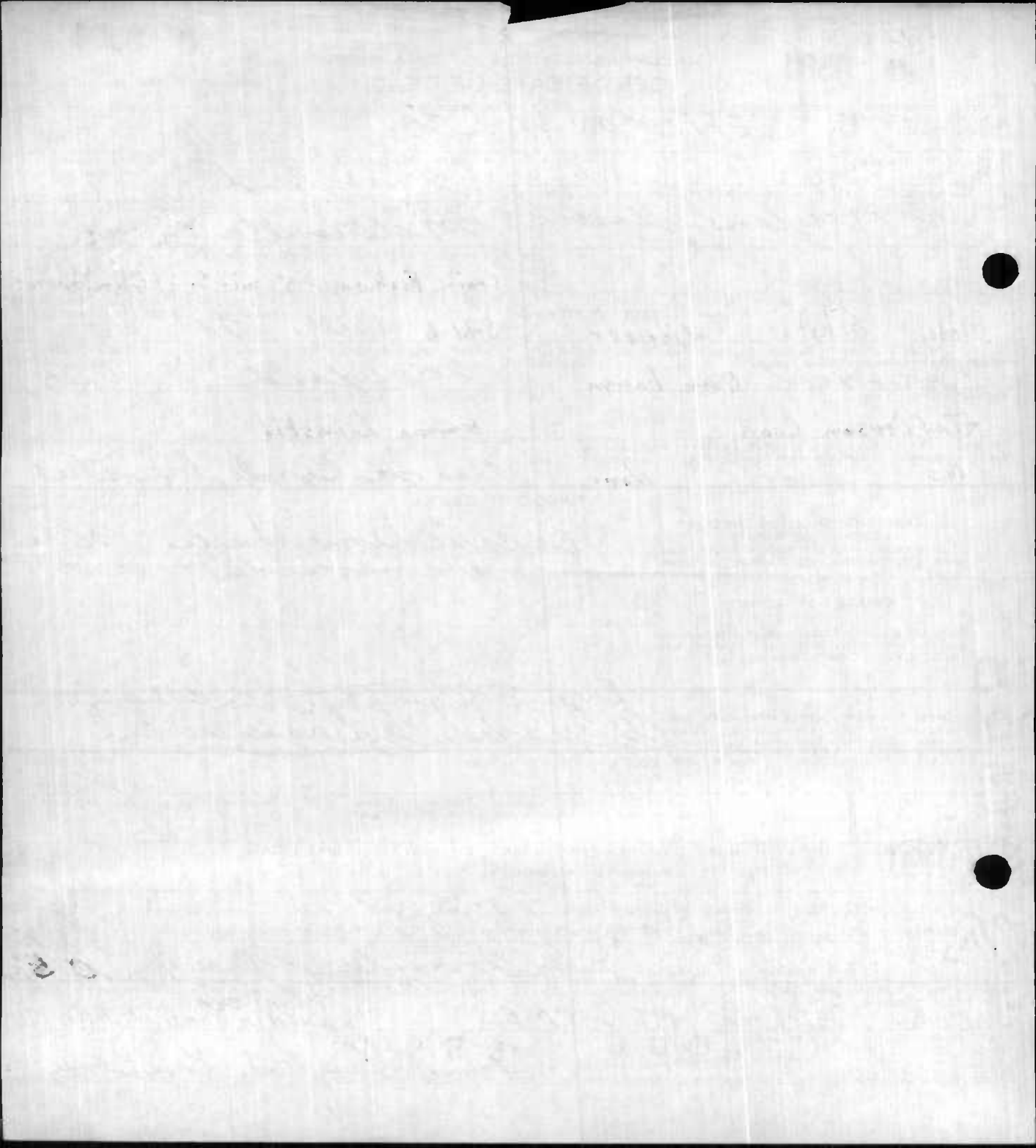
ADDRESS

*OCT-7-1950*

*Thurston Williams, M.D.*

*Thomas W. Singleton*

*Glen Burnie Md.*





Dr - Lachman  
4930 Belair Road

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Louise Noll Eastman

2. DATE  
OF  
DEATH

Oct. 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

4906 Frankford Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

1321 PITTSBURGH ST PA  
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4906 Frankford Avenue

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Feb. 18, 1889

9. AGE (in years-  
last birthday)

61

10. Under 1 Year  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Scranton, Pennsylvania

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Frank B. Noll-

14. MOTHER'S MAIDEN NAME

Emma Guntlock

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Wm. Eastman, 4906 Frankford Ave.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Acute Myocarditis

1 hour

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertensive Cardiovascular Disease

5 years

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 7, 1950, to Oct 7, 1950, that I last saw the deceased alive on Oct 7, 1950, and that death occurred at 3 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

10-11-50

ST. MARY'S CEM

South SCRANTON PA

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

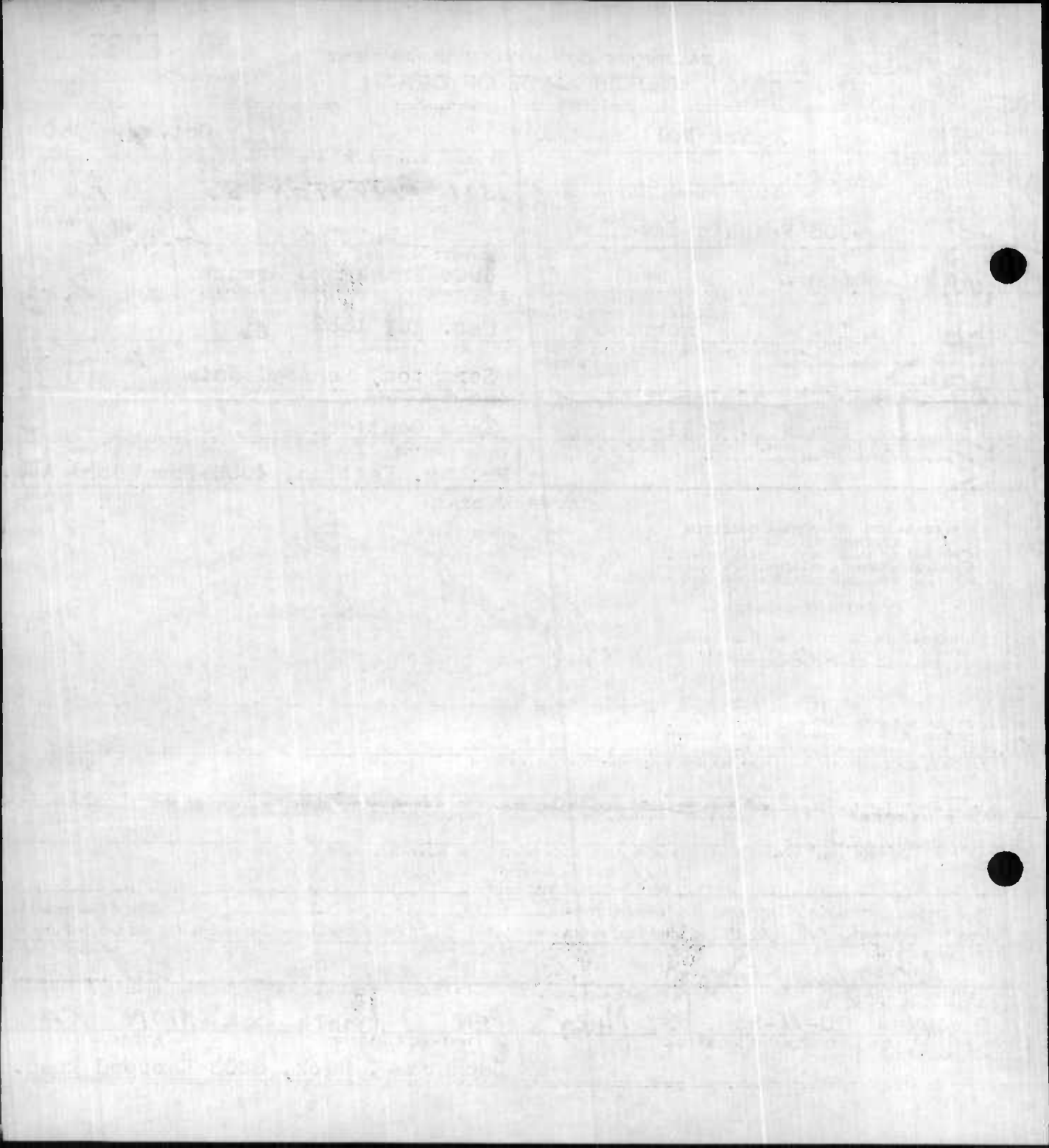
25. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, 5305 Harford Road.

OCT-7-1950

093d



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

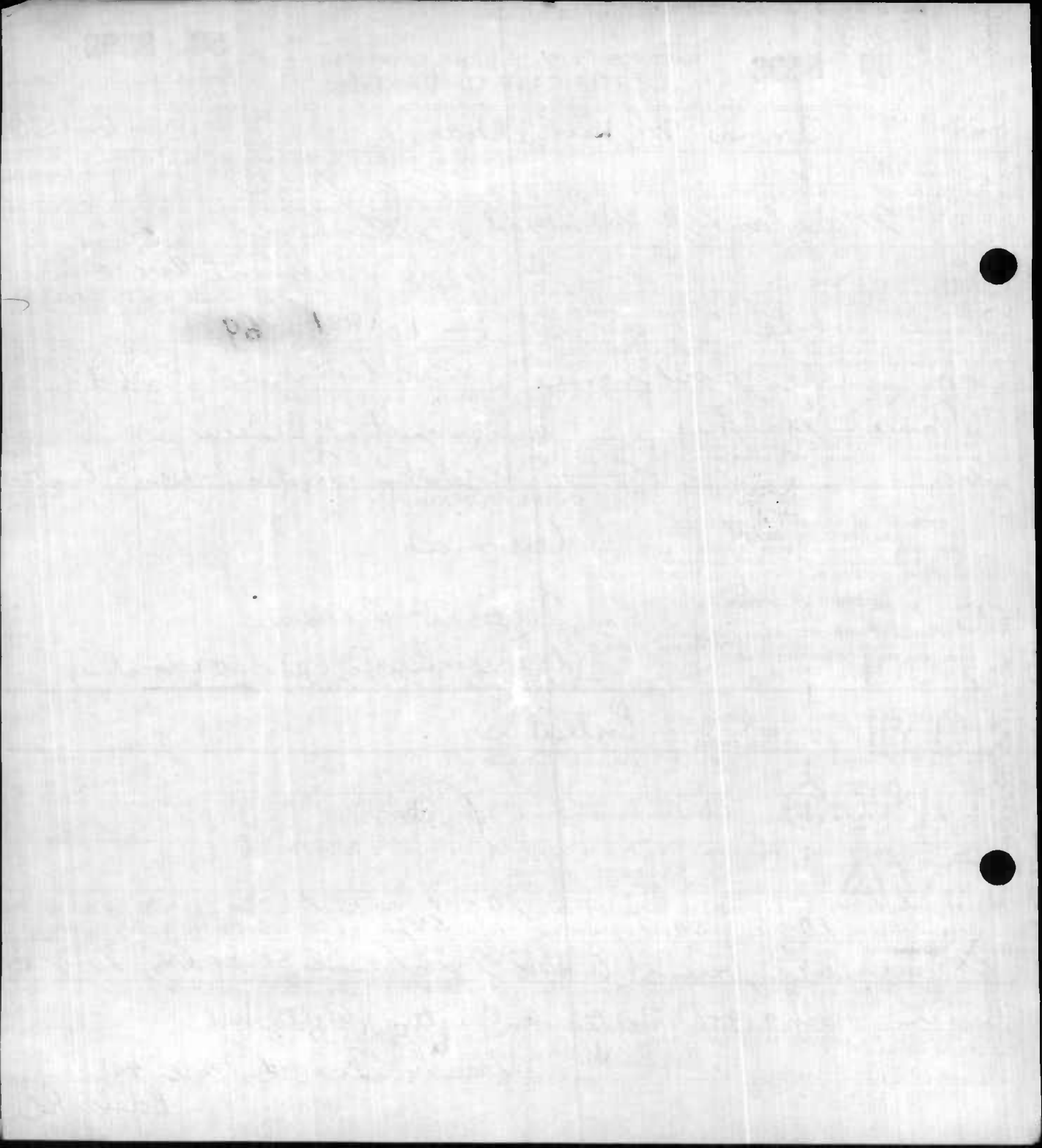
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Anna M. Lingelbach</i>		2. DATE OF DEATH <i>10-6-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>Maryland General Hospital Baltimore 26-01</i>		CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
Length of stay in Baltimore <i>Life</i> Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <i>4206 Parkmont Ave #6</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>1-1-1881</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	9. AGE (in years last birthday) <i>69</i>
13. FATHER'S NAME <i>Daniel Malkus</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. _____	
14. MOTHER'S MAIDEN NAME <i>Margaret Klerlein</i>		17. INFORMANT <i>Mr. Skw. Lingelbach</i>	
ADDRESS <i>4206 Parkmont Ave</i>			

<p>18. <i>442X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH</p> <p>(A) <i>Uremia</i></p> <p>DUE TO</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>(B) <i>Nephrosclerosis</i></p> <p>DUE TO</p> <p>(C) <i>Arteriosclerotic cardiovascular renal disease</i></p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> <p><i>Enteritis</i></p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p>

19A. DATE OF OPERATION <i>2/</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>10-4-1950</i> to <i>10-6-1950</i> , that I last saw the deceased alive on <i>10-6-1950</i> and that death occurred at <i>541</i> pm., from the causes and on the date stated above.					
23A. SIGNATURE <i>Marguerite Cecilia</i>		23B. ADDRESS <i>Maryland General Hospital</i>		23C. DATE SIGNED <i>10-6-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	24B. DATE <i>Oct 9, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Balto, Md.</i>		
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT - 7 1950</i>	REGISTRAR'S SIGNATURE <i>William H. Williams</i>	25. FUNERAL DIRECTOR <i>Lassahn Funeral Home</i>		ADDRESS <i>7401 Belair Rd 131a</i>	



B-260  
8597BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT BAKER		2. DATE OF DEATH Oct. 6, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Rossville</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>City Morgue</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Essex</i>	
Length of stay in Baltimore <i>19</i> Yrs. <i>19</i> Mos. <i>19</i> Days		D. STREET ADDRESS (If rural, give location) <i>Philadelphia &amp; Ridge Rd.</i>	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>3/9/13</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Crane operator</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Bethlehem Steel Co.</i>	9. AGE (In years last birthday) <i>37</i>
11. BIRTHPLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph T. Baker</i>		14. MOTHER'S MAIDEN NAME <i>Fannie M. Wood</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Jos. T. Baker</i>		ADDRESS <i>Galax Va.</i>	

18. <i>E816.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Fracture of skull</i> DUE TO ANTECEDENT CAUSES <i>Multiple contusions and abrasions</i> DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Multiple contusions and abrasions</i> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH
--	----------------------------------

19A. DATE OF OPERATION <i>Oct. 6, 1950</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Road</i>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Route #4 Race Rd. Balto. Co.</i>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>Oct. 6, 1950 12:40 A.m.</i>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <i>Auto &amp; tractor-trailer collision</i>

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>William S. Smith</i>	23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/>	23C. DATE SIGNED <i>Oct. 6, 1950</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>10/8/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Cath Grove Baptist</i>
24D. LOCATION (City, town, or county) <i>Hartford Co.</i>	24E. STATE <i>MD</i>	25. FUNERAL DIRECTOR <i>Lorraine Funeral Home</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>Oct 7 1950</i>		REGISTERAR'S SIGNATURE <i>William S. Smith</i>
ADDRESS <i>7401 Belair Rd.</i>		





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Mary Genevieve Offer</i>		2. DATE OF DEATH <i>OCT. 7, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MO.</i> B. COUNTY <i>BALTO</i>	
8. FULL NAME OF HOSPITAL OR INSTITUTION <i>317 WINSTON AVE</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>BALTO 27-11</i>	
6. Length of stay in Baltimore <i>LIFE</i>		D. STREET ADDRESS (If rural, give location) <i>317 WINSTON AVE</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>AUG. 31, 1890</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>	9. AGE (In years last birthday) <i>53</i>
11. BIRTHPLACE (State or foreign country) <i>MO.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>HARRY SIEGMAN</i>		14. MOTHER'S MAIDEN NAME <i>MARGARET F. BELL</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>WALTER OFFER</i>		ADDRESS <i>SAME</i>	

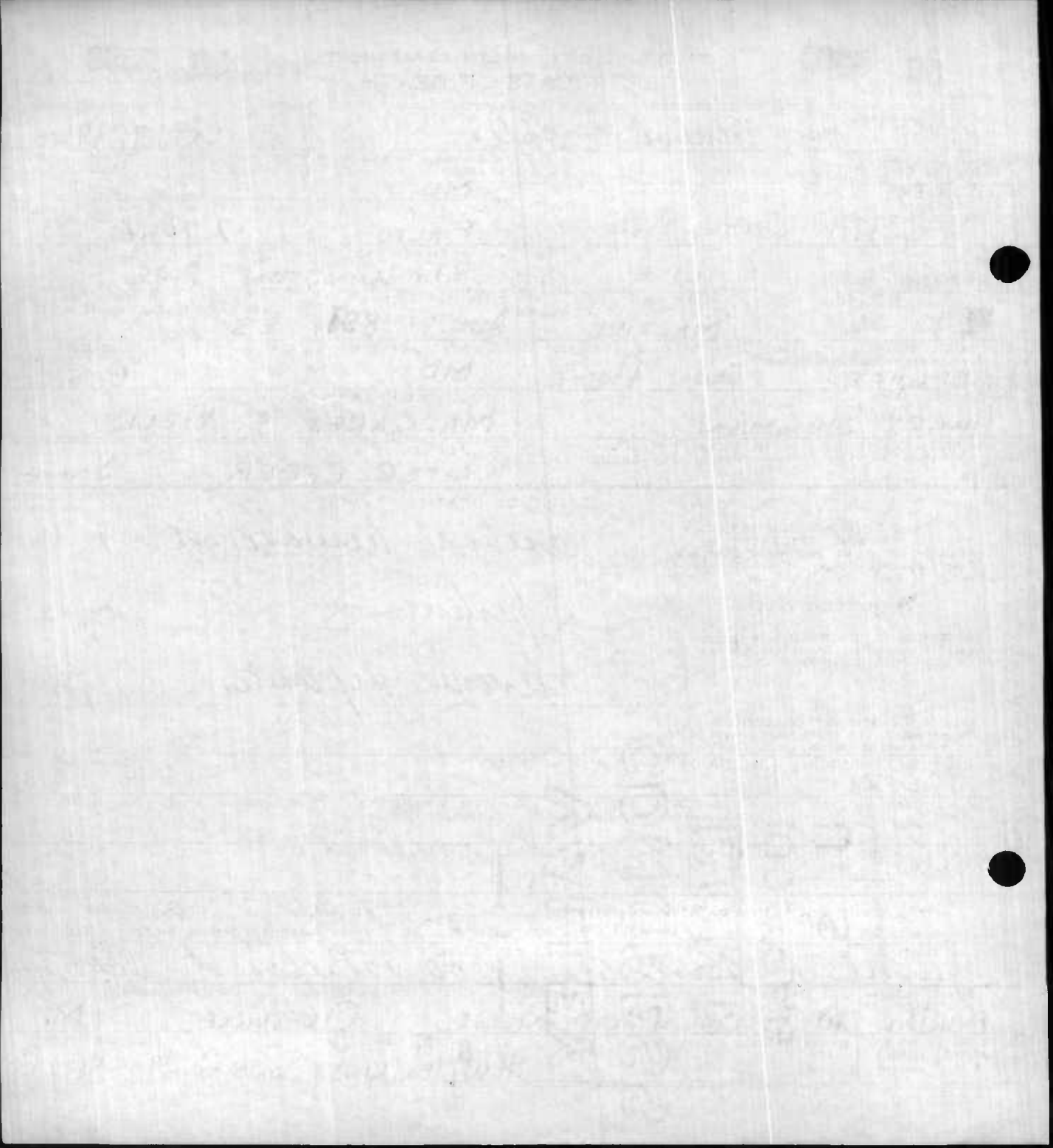
18. <i>592x</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Cerebral hemorrhage</i> DUE TO (B) <i>Hypertension</i> DUE TO (C) <i>Chronic nephritis</i>	INTERVAL BETWEEN ONSET AND DEATH <i>1 wk.</i>  <i>10 yrs.</i>  <i>10 yrs.</i>
---	---	--

19A. DATE OF OPERATION <i>None</i>	19B. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>None</i>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from *1949* to *OCT 7*, 19*50* that I last saw the deceased alive on *OCT 7, 1950* and that death occurred at *2:15* A. M., from the causes and on the date stated above.

23A. SIGNATURE *James R. Karns* M. D. 23B. ADDRESS *700 Cathedral St* 23C. DATE SIGNED *OCT 7, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>10-9-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>DRUID RIDGE</i>	24D. LOCATION (City, town, or county) (State) <i>PIKESVILLE MD.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 7 1950</i>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR <i>H. W. JENKINS &amp; SONS Co.</i> ADDRESS <i>4905 York Rd</i>	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**AUGUSTUS FAUNTLEROY**

2. DATE  
OF  
DEATH

**Oct. 4, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

**Maryland**

B. COUNTY

\_\_\_\_\_

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

**2016 N. Monroe Street**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore**

D. STREET ADDRESS (If rural, give location)

**2016 N. Monroe Street**

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

**Male**

6. COLOR OR RACE

**Colored**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Married**

8. DATE OF BIRTH

**July 20, 1903**

9. AGE (In years last birthday)

**47**

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Laborer**

10B. KIND OF BUSINESS OR INDUSTRY

**Coal company**

11. BIRTHPLACE (State or foreign country)

**Lancaster, Va.**

12. CITIZEN OF WHAT COUNTRY?

**USA**

13. FATHER'S NAME

**Mannie Fauntleroy**

14. MOTHER'S MAIDEN NAME

**Annie ????????**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
**Mrs. Sedonba Fauntleroy  
2016 N. Monroe Street**

18. **581.0**

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) \_\_\_\_\_

**Cirrhosis of the Liver - Cause Unknown**

**9-1-50**

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_

**Secondary Anemia**

**9-1-50**

DUE TO

(C) \_\_\_\_\_

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

**Acute Arthritis**

**7-10-50**

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **7-10**, 19**50** to **10/4**, 19**50** that I last saw the deceased alive on **10/4**, 19**50** and that death occurred at **12:30 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

**1131 Harlem Avenue**

**10/7/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR ADDRESS

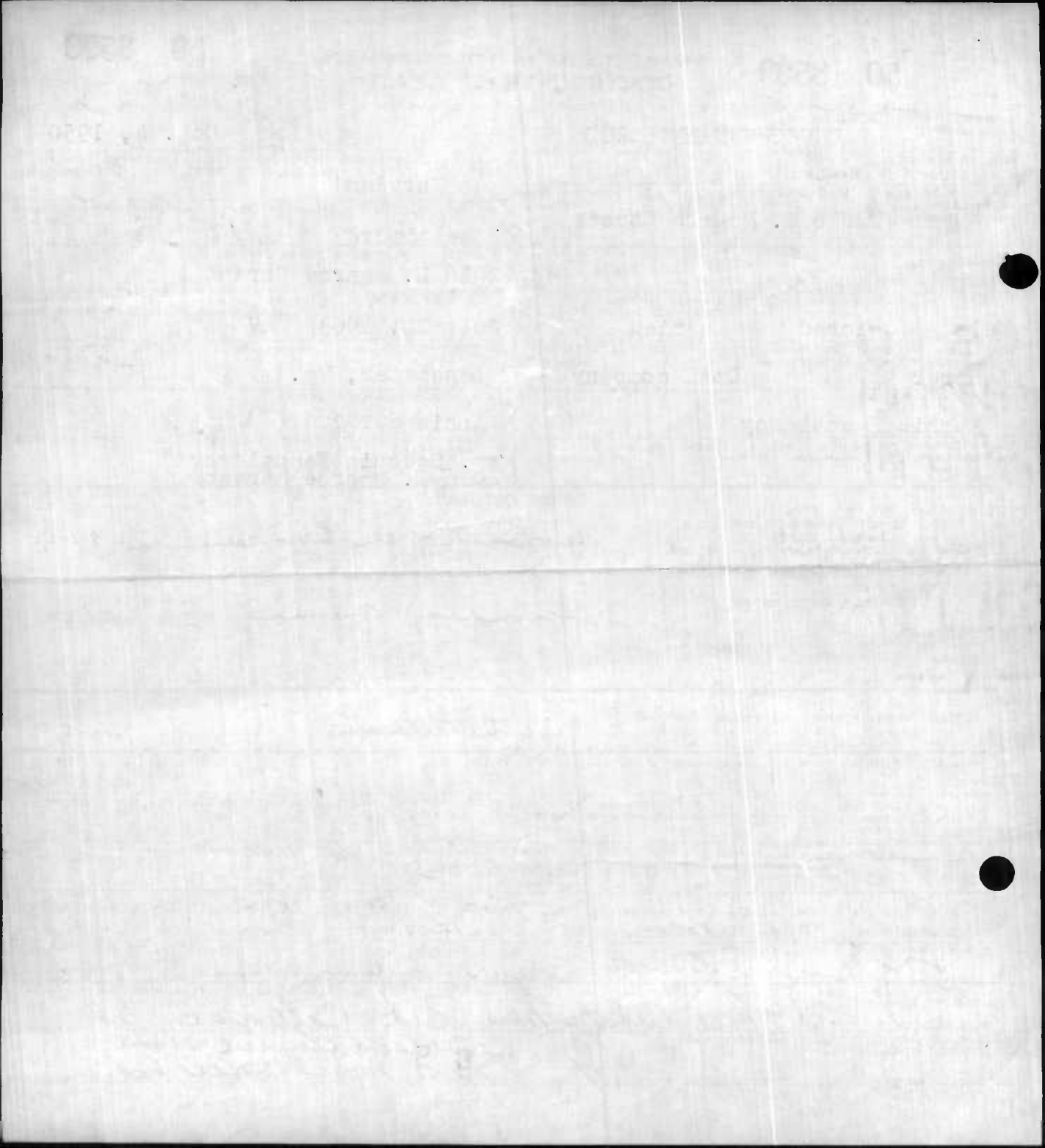
**OCT 7 1950**

**Washington Williams**

**1508 North Howard Street  
East David Hill Ave.**

**9706T**

**1246**



C-462

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Clarke Baby Boy

2. DATE  
OF  
DEATH

10/6/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

South Baltimore General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1605 Light Street

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

10/5

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

20 15

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Norbert E. Clarke

14. MOTHER'S MAIDEN NAME

Margaret Dean

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Norbert E. Clarke 1605 Light St.,

18. 776x

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) \_\_\_\_\_

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_

DUE TO

(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 10/5/50, 19\_\_, to 10/6/50, 19\_\_, that I last saw the  
deceased alive on 10/6/50, 19\_\_, and that death occurred at 4:54 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

10-7-1950

Cedar Hill

Brooklyn

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

G. Howard Strong 3207 W. North Ave.,

VS 150

OCT 7 - 1950

159.0

MEDICAL CERTIFICATION





G-460  
50 8601BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8601

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Isabel B. Callagher (Mrs. DeWitt)</i>			2. DATE OF DEATH <i>October 6, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>West Virginia</i> B. COUNTY <i>Kanawha</i> <i>V-45</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Charleston</i>		
Length of stay in Baltimore Yrs. <i>1</i> Mos. <i>1</i> Days <i>1</i>			D. STREET ADDRESS (If rural, give location) <i>5 Grosscup Road</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>June 16, 1895</i>	9. AGE (In years last birthday) <i>55</i>	If Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>	
13. FATHER'S NAME <i>Thomas C. Beury</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>MR DEWITT CALLAHER - CHARLESTON W. VA</i>			ADDRESS		

18. *151X* CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
(A) *Acute Empyema - Sept.* DUE TO  
INTERVAL BETWEEN ONSET AND DEATH  
*8 da.*

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
(B) DUE TO  
(C) *Carcinoma of Stomach (cardia)* ?

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <i>Sept 29, 1950</i>		19B. MAJOR FINDINGS OF OPERATION <i>Carcinoma of Cardia of Stomach</i>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *Sept 7*, 1950 to *Oct 6*, 1950 that I last saw the deceased alive on *Oct 6*, 1950, and that death occurred at *PM.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Alvin Bompliar</i> M. D.		23B. ADDRESS <i>Union Memorial Hosp.</i>		23C. DATE SIGNED <i>Oct 6, 1950</i>	
---	--	---	--	--	--

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>Oct 7/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Charleston West Virginia</i>		24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>William M. Williams</i>		25. FUNERAL DIRECTOR <i>Harry A. Wipke</i>		ADDRESS <i>4101 Edmondson Ave</i>	

VS-15050

0466

1. The first part of the paper is devoted to a general  
discussion of the subject. It is shown that the  
theory of the subject is very simple and that  
it can be applied to a wide range of cases.  
The second part of the paper is devoted to a  
detailed discussion of the theory. It is shown  
that the theory is very general and that it  
can be applied to a wide range of cases.

The third part of the paper is devoted to a  
detailed discussion of the theory. It is shown  
that the theory is very general and that it  
can be applied to a wide range of cases.  
The fourth part of the paper is devoted to a  
detailed discussion of the theory. It is shown  
that the theory is very general and that it  
can be applied to a wide range of cases.

The fifth part of the paper is devoted to a  
detailed discussion of the theory. It is shown  
that the theory is very general and that it  
can be applied to a wide range of cases.  
The sixth part of the paper is devoted to a  
detailed discussion of the theory. It is shown  
that the theory is very general and that it  
can be applied to a wide range of cases.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Lester Franklin Bohlayer</b>		2. DATE OF DEATH <b>Oct. 7, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Lutherville</b>	
Length of stay in Baltimore <b>1</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>Balonia Ave.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>September 25, 1915</b> 35
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Elec. Co.</b>	9. AGE (In years last birthday) <b>35</b>
11. BIRTHPLACE (State or foreign country) <b>Freeland, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John A. Bohlayer</b>		14. MOTHER'S MAIDEN NAME <b>Elsie Stenbaker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Isabelle Bohlayer, Lutherville, Md.</b>		ADDRESS	

18. <b>E914.3</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <b>Electrocution</b> DUE TO _____ ANTECEDENT CAUSES (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO _____ (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH
--	----------------------------------

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>New Gate Station of Gas &amp; Electric Co.</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>5200 New Gate Avenue Baltimore City</b>
21D. TIME (Month) (Day) (Year) (Hour) <b>Oct. 7, 1950 8 A.m.</b>	21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Contact with high voltage electric current</b>

22. I certify that I took charge of the remains described above, held an **Inspection & Inq.** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, **accident** ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>William Wood</b>	23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/>	23C. DATE SIGNED <b>Oct. 7, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Oct. 10, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery, Freeland, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>Oct 8 - 1950</b>	REGISTRAR'S SIGNATURE <b>Wm. Wood</b>	25. FUNERAL DIRECTOR <b>Jacob Hartenstein, New Freedom, Pa.</b>

100-100000

DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of coroner		12. Signature of jury	
13. Signature of witness		14. Signature of witness		15. Signature of witness	
16. Signature of witness		17. Signature of witness		18. Signature of witness	
19. Signature of witness		20. Signature of witness		21. Signature of witness	
22. Signature of witness		23. Signature of witness		24. Signature of witness	
25. Signature of witness		26. Signature of witness		27. Signature of witness	
28. Signature of witness		29. Signature of witness		30. Signature of witness	
31. Signature of witness		32. Signature of witness		33. Signature of witness	
34. Signature of witness		35. Signature of witness		36. Signature of witness	
37. Signature of witness		38. Signature of witness		39. Signature of witness	
40. Signature of witness		41. Signature of witness		42. Signature of witness	
43. Signature of witness		44. Signature of witness		45. Signature of witness	
46. Signature of witness		47. Signature of witness		48. Signature of witness	
49. Signature of witness		50. Signature of witness		51. Signature of witness	
52. Signature of witness		53. Signature of witness		54. Signature of witness	
55. Signature of witness		56. Signature of witness		57. Signature of witness	
58. Signature of witness		59. Signature of witness		60. Signature of witness	
61. Signature of witness		62. Signature of witness		63. Signature of witness	
64. Signature of witness		65. Signature of witness		66. Signature of witness	
67. Signature of witness		68. Signature of witness		69. Signature of witness	
70. Signature of witness		71. Signature of witness		72. Signature of witness	
73. Signature of witness		74. Signature of witness		75. Signature of witness	
76. Signature of witness		77. Signature of witness		78. Signature of witness	
79. Signature of witness		80. Signature of witness		81. Signature of witness	
82. Signature of witness		83. Signature of witness		84. Signature of witness	
85. Signature of witness		86. Signature of witness		87. Signature of witness	
88. Signature of witness		89. Signature of witness		90. Signature of witness	
91. Signature of witness		92. Signature of witness		93. Signature of witness	
94. Signature of witness		95. Signature of witness		96. Signature of witness	
97. Signature of witness		98. Signature of witness		99. Signature of witness	
100. Signature of witness		101. Signature of witness		102. Signature of witness	

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Ida K. Price</i>		2. DATE OF DEATH <i>Oct-6, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>3032 Pinewood Ave</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto</i> <i>27-05</i>	
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <i>3032 Pinewood Ave.</i>	
5. SEX <i>7-</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>Dec 30 1855</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>94</i>
11. BIRTHPLACE (State or foreign country) <i>Detroit, Mich</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edward Kirkpatrick</i>		14. MOTHER'S MAIDEN NAME <i>Charles Catherine Pearl</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>	16. SOCIAL SECURITY NO. <i>no.</i>	17. INFORMANT ADDRESS <i>Mrs Pearl P. Clark, 3032 Pinewood Ave</i>	

**CAUSE OF DEATH**

18. <i>442X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  (A) <i>Generalized arteriosclerosis</i> DUE TO _____  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (B) <i>Arteriosclerotic cardiovascular renal disease</i> DUE TO _____  (C) _____  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH  ?  ?
--	--

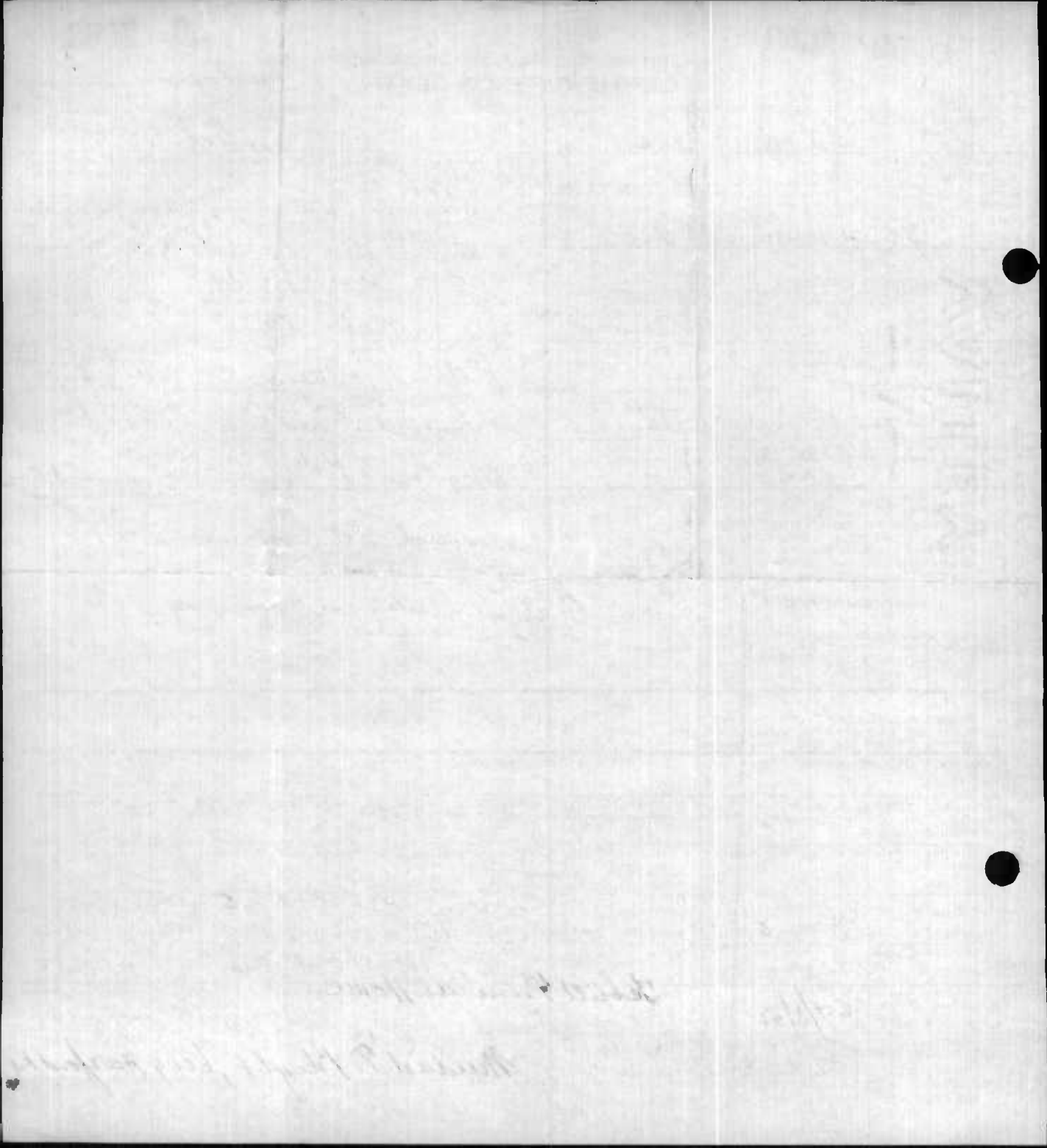
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *March*, 19*43*, to *October 6*, 19*50*, that I last saw the deceased alive on *October 6*, 19*50*, and that death occurred at *4:02* m., from the causes and on the date stated above.

23A. SIGNATURE <i>Salesman</i>	23B. ADDRESS <i>6217 Harford Rd</i>	23C. DATE SIGNED <i>10/7/50</i>
-----------------------------------	--	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal.</i>	24B. DATE <i>Oct 8/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Albany Rural Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>Albany, New York.</i>
--	------------------------------	--	---

DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 8 - 1950</i>	REGISTRAR'S SIGNATURE <i>Thurston Williams, M.D.</i>	25. FUNERAL DIRECTOR <i>Mildred T. Blight, 6009 Harford Rd</i>	ADDRESS
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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>CELIA SHERR</b>			2. DATE OF DEATH <b>October 6, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>2642 Oswego Avenue</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
D. STREET ADDRESS (If rural, give location) <b>2642 Oswego Avenue</b>			E. Length of stay in Baltimore <b>55 yrs.</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>9/18/79</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Year Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Joseph Balk</b>			14. MOTHER'S MAIDEN NAME <b>Hannah ???</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Anne Sherr- 2642 Oswego Avenue</b>		

18. <b>163x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <b>Carcinoma of Lung</b> DUE TO (B) _____ DUE TO (C) _____ <b>Diabetes Mellitus</b>	INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>  <b>24 yrs</b>
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19A. DATE OF OPERATION <b>10/6/50</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **1948**, to **10/6**, 19**50**, that I last saw the deceased alive on **10/6**, 19**50**, and that death occurred at **10 P** m., from the causes and on the date stated above.

23A. SIGNATURE <b>Edward O. Kalline</b>	23B. ADDRESS <b>1847 W. North Ave</b>	23C. DATE SIGNED <b>10/7/50</b>
--	--	------------------------------------

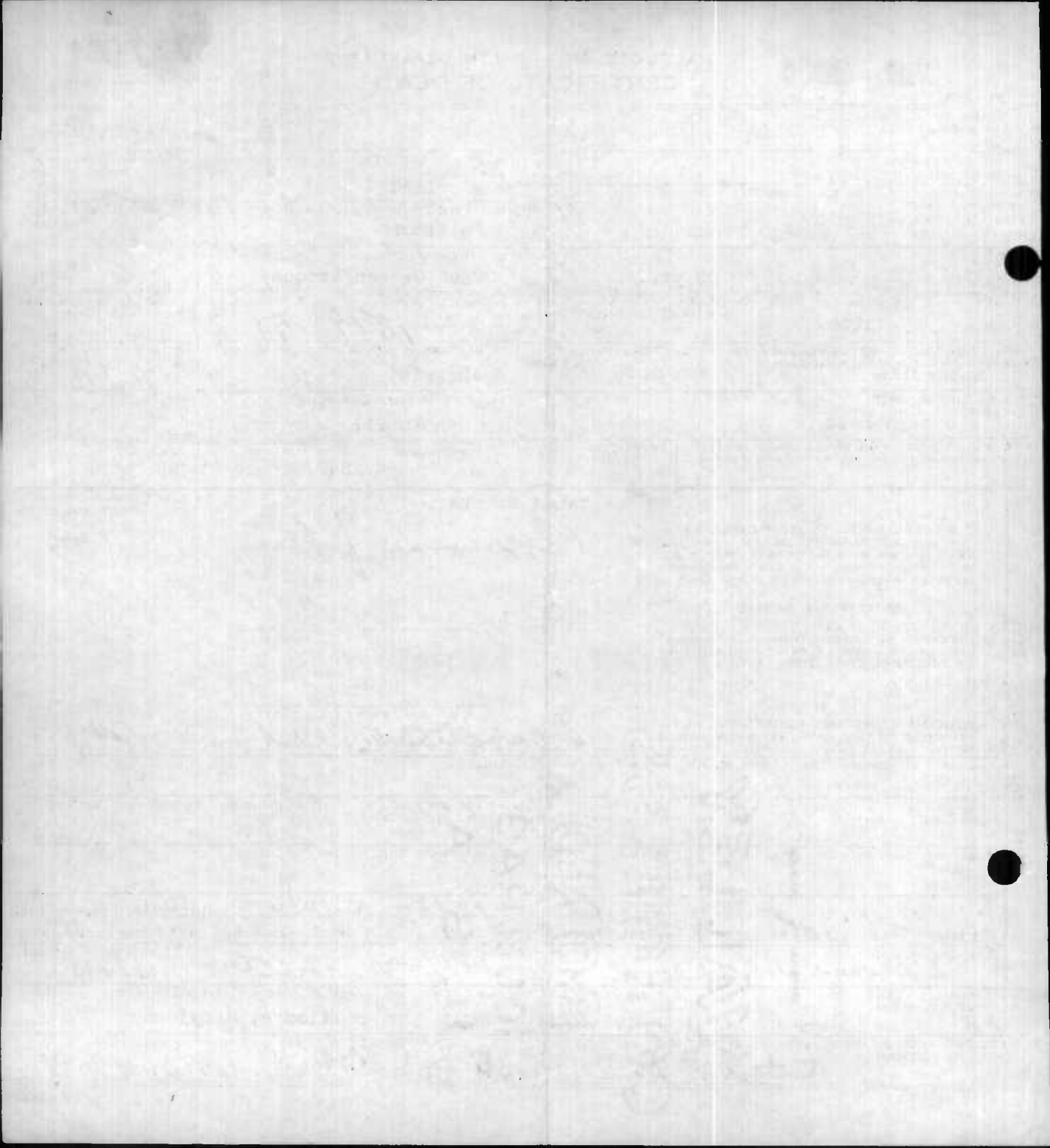
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-8-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Anshei Emunah Cong.</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
--	-----------------------------	--	---

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>Wm. H. Williams</b>	25. FUNERAL DIRECTOR <b>Sol. Reinson &amp; Bros</b>	ADDRESS <b>-1124-26 W. North Avenue</b>
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0018-1950

047d

MEDICAL CERTIFICATION



B-620

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-03716

1. NAME OF DECEASED  
(Type or Print)

Michael Henry Brooks

2. DATE  
OF  
DEATH

Oct. 7, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hospital

Yrs.  
Mos.  
Days

Length of stay in Baltimore

8 mo.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

S

10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR  
INDUSTRY

None

13. FATHER'S NAME

Henry Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
a. STATE b. COUNTY before admission)

Md

Baltimore

c. CITY OR TOWN. (If outside corporate limits, write RURAL and give township)

Baltimore

5300

d. STREET ADDRESS (If rural, give location)

2802 Onyx Ave

8. DATE OF BIRTH

Feb 17, 1950

9. AGE (in years  
last birthday)

0

If Under 1 Year  
Months: Days

7 20

If Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Alma Ward

17. INFORMANT

Father

ADDRESS

2802 Onyx Ave Balt.

18. 228X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

Mechanical Suffocation

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Stenosis of trachea

DUE TO

(C)

Hemangioma of trachea

INTERVAL BETWEEN  
ONSET AND DEATH

7

Congestive

"

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

Aug 16, 1950

19b. MAJOR FINDINGS OF OPERATION

Hemangioma of Trachea

20. AUTOPSY?

YES ☒ NO ☐21a. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-2-50 to 10-7-50, that I last saw the  
deceased alive on 10-7-50 and that death occurred at 2:55 P. M., from the causes and on the date stated above.

23a. SIGNATURE

Francis A. Ware

M. D.

23b. ADDRESS

Union Memorial Hosp

23c. DATE SIGNED

10-9-50

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24b. DATE

Oct 10

24c. NAME OF CEMETERY OR CREMATORY

Parkwood cemetery

24d. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

OCT 8 - 1950

REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

Sasha's Funeral Home

ADDRESS

VS 150

1572

MEDICAL CERTIFICATION

*[Faint, illegible handwriting on lined paper]*

A-552.

50 8606

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8606

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ADELINE AMONICA</b>			2. DATE OF DEATH <b>Oct. 5th 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland 406 S. Exeter St.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>-2-02</b>		
E. Length of stay in Baltimore <b>25 Yrs.</b>			D. STREET ADDRESS (If rural, give location) <b>406 S. Exeter St.</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 3 1901</b>		9. AGE (In years, last birthday) <b>49</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Larino Italy</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Michele De Lena</b>			14. MOTHER'S MAIDEN NAME <b>Antonetta Caravina</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		

18. **422.1**

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Myocardial Insufficiency****5 days**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Coronary Vascular Disease****8 months**

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **0** 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **March 20th, 1950** to **Sept 30th, 1950**, that I last saw the deceased alive on **Sept 07, 1950**, and that death occurred at **10 a. m.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

**Burial****Oct. 9 1950****Holy Redeemer Cemetery****4430 Belair Balti. Md.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**OCT-8-1950****Emmington Williams, M.D.****Frank Della Koe****322 S. High St.**

VS 150

093d

MEDICAL CERTIFICATION

373 63

AUSTRIA - AMERICA

2000 1000 500

100

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1000 1000 500

1000 1000 500

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H-553  
50 8607BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 8607

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MR. WALTER CARLISLE HAMMOND</b>			2. DATE OF DEATH <b>OCT. 6, 1950</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MD.</b> b. COUNTY		
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 15 15-10</b>		
Length of stay in Baltimore Yrs. Mos. Days			d. STREET ADDRESS (If rural, give location) <b>4104 RIDGEWOOD AVE.</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>M</b>	8. DATE OF BIRTH <b>FEB. 6, 1884</b>	9. AGE (in years last birthday) <b>66</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CREDIT MANAGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FURNITURE STORE</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>HENRY DORSEY HAMMOND</b>			14. MOTHER'S MAIDEN NAME <b>MARY ROSALIE WALSH</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>UNK.</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>DECEASED'S WIFE</b>		ADDRESS <b>SAME</b>

18. **420.0**

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)(A) **Congestive Heart Failure**  
DUE TO

?

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Arteriosclerotic Heart Disease**  
DUE TO

?

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION **2**

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21a. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) **F** INJURY

21e. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **OCT. 2**, 19**50**, to **OCT. 6**, 19**50**, that I last saw the deceased alive on **OCT. 6**, 19**50**, and that death occurred at **7:15 P** m., from the causes and on the date stated above.

23a. SIGNATURE

M. D.

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

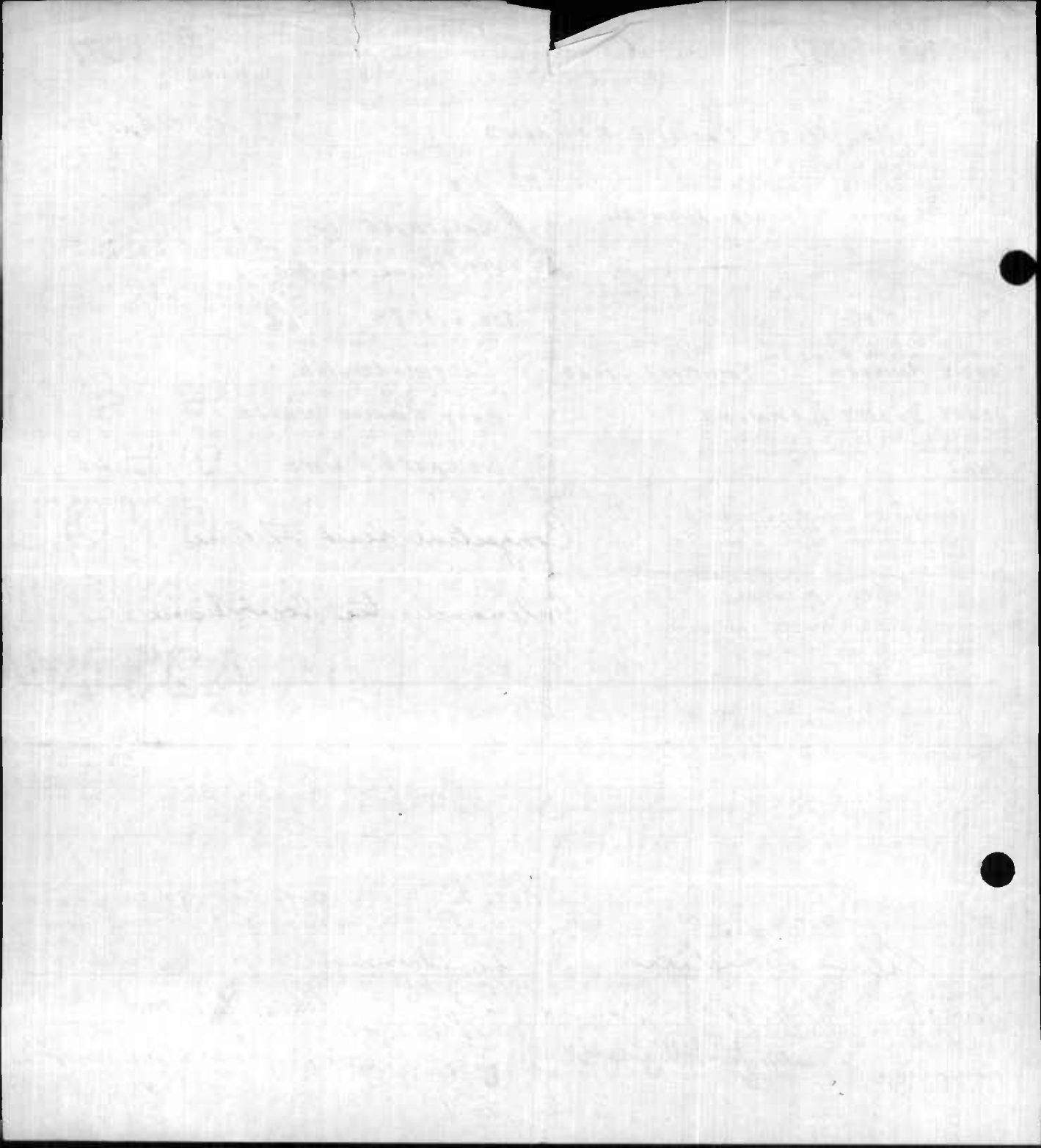
ADDRESS

OCT 15 8d 1950

30066

093d

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

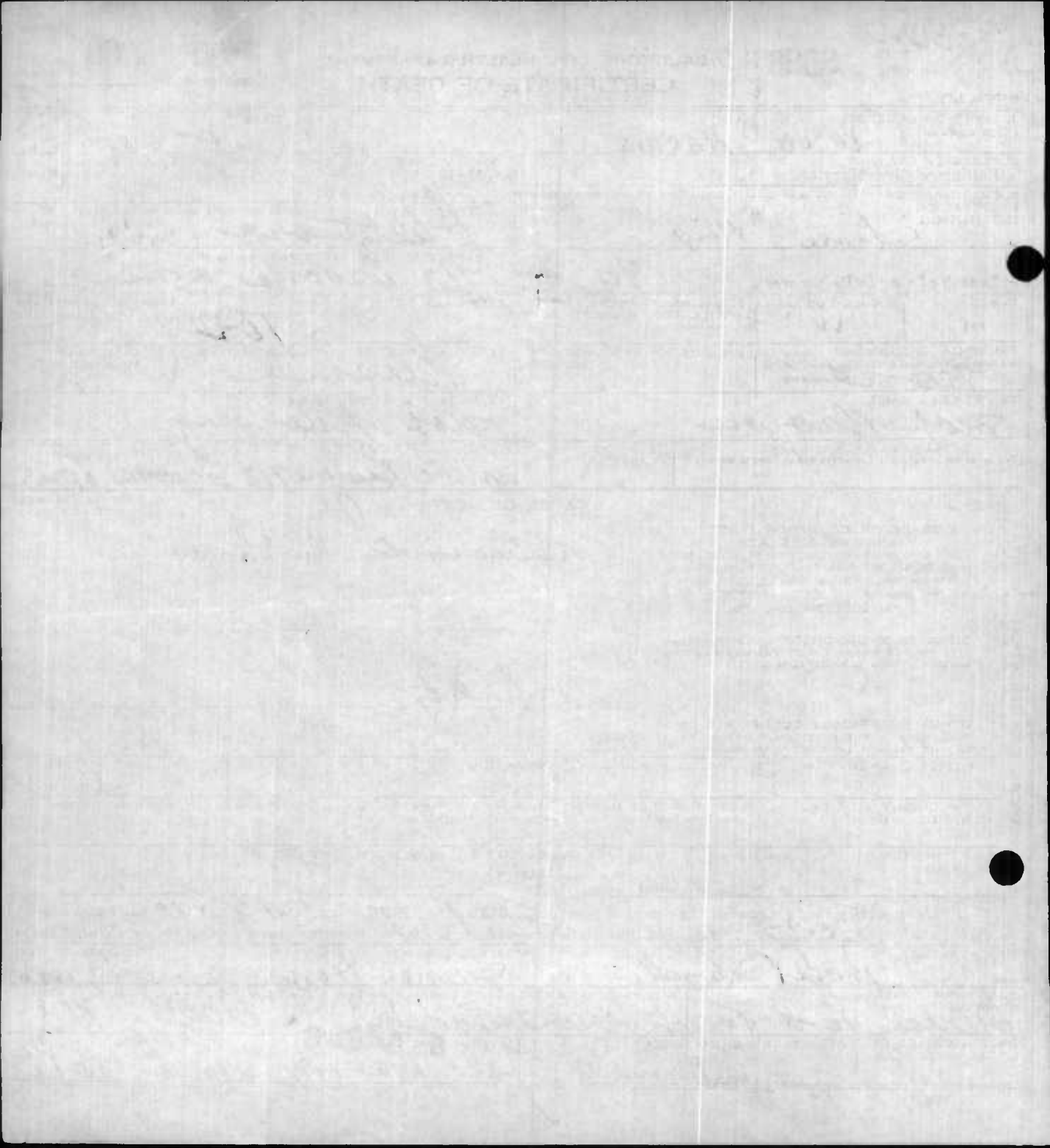
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>JACOB HARRIS</b>		2. DATE OF DEATH <b>Oct 7, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hosp</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>713 Brooks Lane</b>		E. _____	
c. Length of stay in Baltimore <b>90</b> Yrs. <b>102</b> Mos. <b>13-01</b> Days		5. DATE OF BIRTH _____	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	9. AGE (In years, last birthday) <b>102</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <b>Not known</b>		14. MOTHER'S MAIDEN NAME <b>Not known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Minnie Levy</b>		ADDRESS <b>- 713 Brooks Lane</b>	

<p>18. <b>420.0</b></p> <p><b>I</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p align="center"><b>CAUSE OF DEATH</b></p> <p>(A) <b>Arteriosclerotic Heart Disease</b></p> <p align="center"><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p align="center"><b>CAUSE OF DEATH</b></p> <p>(A) <b>Arteriosclerotic Heart Disease</b></p> <p align="center"><b>INTERVAL BETWEEN ONSET AND DEATH</b></p> <p>(B) _____</p> <p align="center"><b>Anterior</b></p> <p>(C) <b>Senility</b></p>

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
<p>22. I hereby certify that I attended the deceased from <b>Oct 1, 1950</b>, to <b>Oct 7, 1950</b>, that I last saw the deceased alive on <b>Oct 7, 1950</b>, and that death occurred at <b>3:10 p.m.</b>, from the causes and on the date stated above.</p>					
23A. SIGNATURE <b>Robert Kneller</b>		23B. ADDRESS <b>M. D. Sinai Hosp</b>		23C. DATE SIGNED <b>Oct 7, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-8-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Hebrew Friendship</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md</b>		24E. NAME OF CEMETERY OR CREMATORY <b>Hebrew Friendship</b>		24F. LOCATION (City, town, or county) <b>Baltimore, Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>Oct 8 1950</b>		REGISTRAR'S SIGNATURE <b>William M. ...</b>		25. FUNERAL DIRECTOR <b>Jack Lewis</b>	
ADDRESS <b>2100 Eutaw Pl</b>					



7-150

8609

Certificate corrected 10-16-50

50

8609

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FANNIE LEVIN

2. DATE  
OF  
DEATH

10-6-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

233 So Broadway

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

233 So Broadway

E. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months: Days

Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 157X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Thrombosis of left subclavian artery

3 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1950, to Oct. 6, 1950, that I last saw the deceased alive on 10/6/50, and that death occurred at 3:45 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

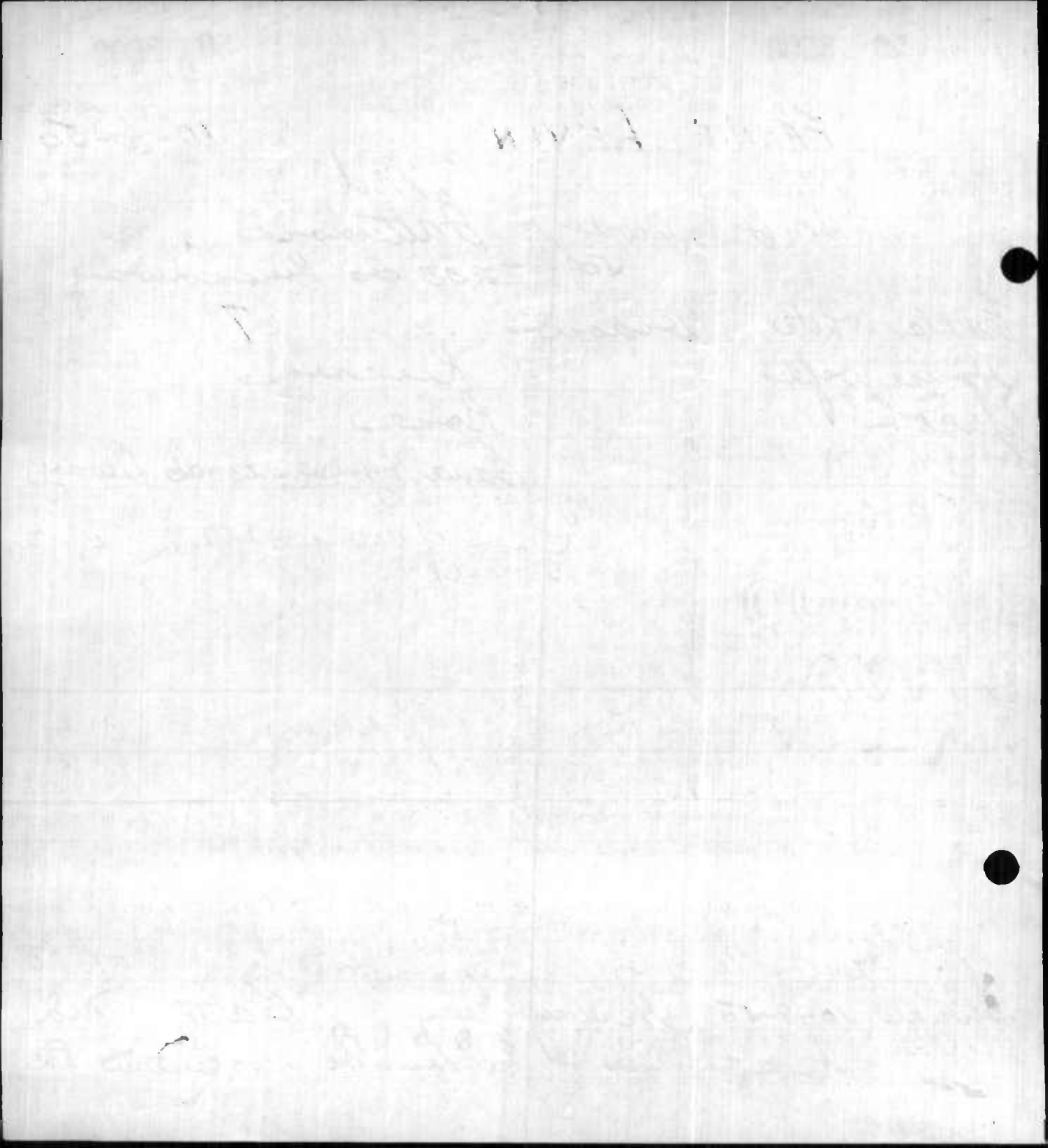
ADDRESS

Funerary Services, Inc. 2100 Eutan Pl

DCT VS-150

0469

MEDICAL CERTIFICATION





R-400610

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8610

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Reverend Wendall S. Reilly S.S.

2. DATE  
OF  
DEATH

October 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

8. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Jenkins Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

27-13

O. STREET ADDRESS (If rural, give location)

Roland &amp; Belvedere Avenues

C. Length of stay in Baltimore

30 Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

March 25, 1875

9. AGE (In years last birthday)

75

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Priest

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

CANADA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Not obtainable

14. MOTHER'S MAIDEN NAME

Not obtainable

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Hospital Record

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CONGESTIVE FAILURE

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) BRONCHOPNEUMONIA

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 7/1, 1950 to 10/7, 1950, that I last saw the deceased alive on 10/7, 1950, and that death occurred at 10:00 AM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

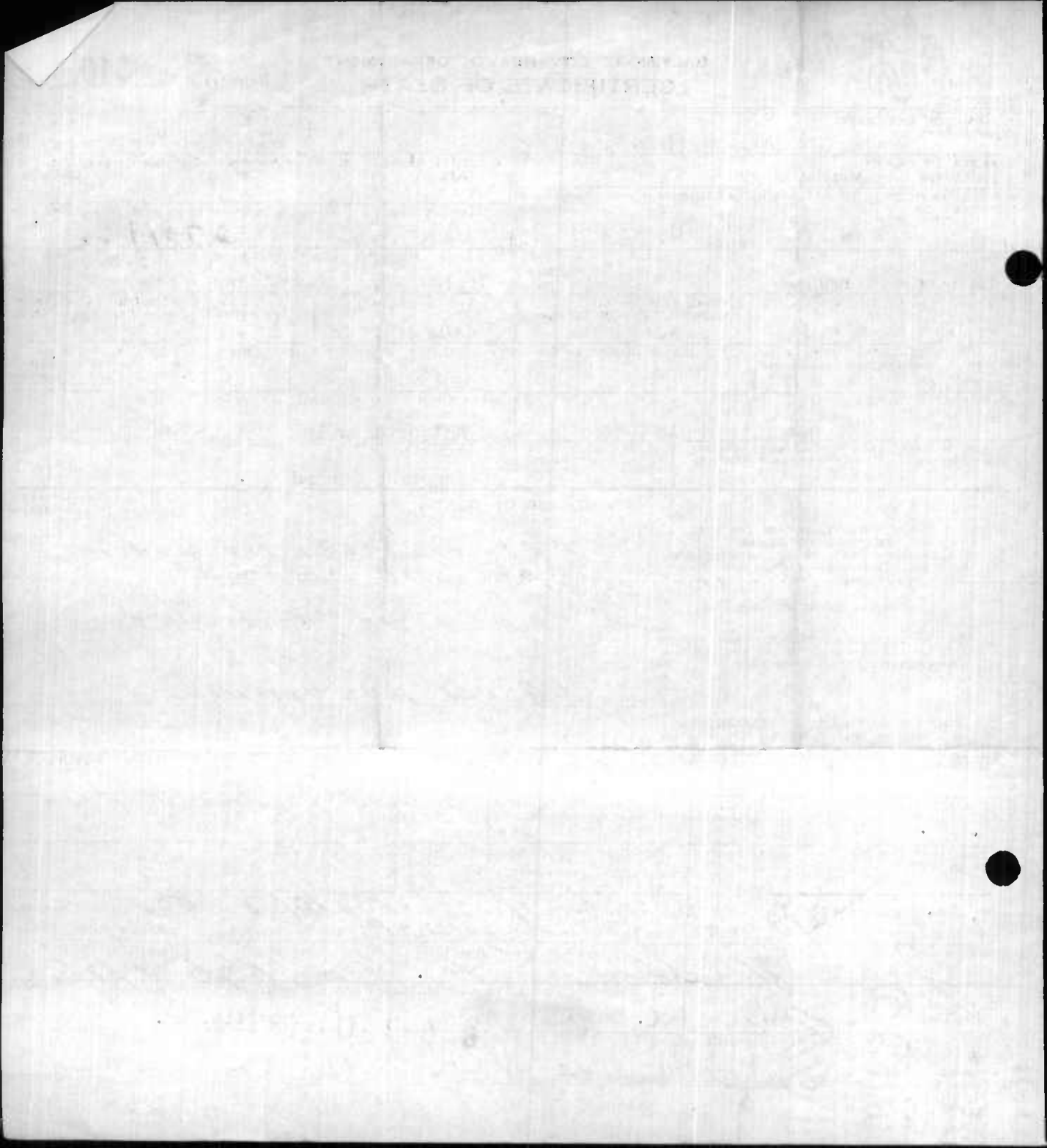
REGISTRAR'S SIGNATURE

25. GENERAL DIRECTOR

ADDRESS

OCT - 81950

0932



M-216

50 8611

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN WALDRON MCGOVERN</b>			2. DATE OF DEATH <b>OCT. 6, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		
5. FULL NAME OF (If not in hospital or institution, give street address or location) <b>2920 CRESMONT AVE.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 12-06</b>		
6. Length of stay in Baltimore <b>65</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>2920 CRESMONT AVE.</b>		
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M.</b>	8. DATE OF BIRTH <b>JUNE 3, 1885</b>	9. AGE (In years; last birthday) <b>65</b>	10. Under 1 Year Months: Days <b>* 0</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ASST. MGR. ACCT. INK. CASUALTY INS. CO.</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		
13. FATHER'S NAME <b>JAMES PAUL MCGOVERN</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
14. MOTHER'S MAIDEN NAME <b>CLARA MARY SHAUGHNESSY</b>			17. INFORMANT ADDRESS <b>MRS. MARGARET MCGOVERN 2920 CRESMONT AVE.</b>		

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH  (A) <b>CEREBRAL HEMORRHAGE</b> DUE TO  (B) <b>HYPERTENSIVE CARDIO-VASCULAR DISEASE</b> DUE TO  (C)	INTERVAL BETWEEN ONSET AND DEATH  <b>13 DAYS.</b>  <b>(?) YEARS</b>
--	--	---

19A. DATE OF OPERATION <b>NONE</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>No</b>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **3-29**, 19**50**, to **10-6-**, 19**50**, that I last saw the deceased alive on **10-6-**, 19**50**, and that death occurred at **9.23 P.m.**, from the causes and on the date stated above.

23A. SIGNATURE  
**Arthur Karfagin**  
M. O. **4230 Loch Raven Blvd.**

23B. ADDRESS  
**4230 Loch Raven Blvd.**

23C. DATE SIGNED  
**10-6-50**

24A. BURIAL, CREMATION, REMOVAL (Specify)  
**Burial**

24B. DATE  
**10/10/50**

24C. NAME OF CEMETERY OR CREMATORY  
**New Cathedral**

24D. LOCATION (City, town, or county) (State)  
**Baltimore, Md.**

DATE RECEIVED BY LOCAL REGISTRAR  
**Oct 15 1950**

REGISTRAR'S SIGNATURE  
**Huntington Williams**

25. FUNERAL DIRECTOR  
**W. B. Williams**

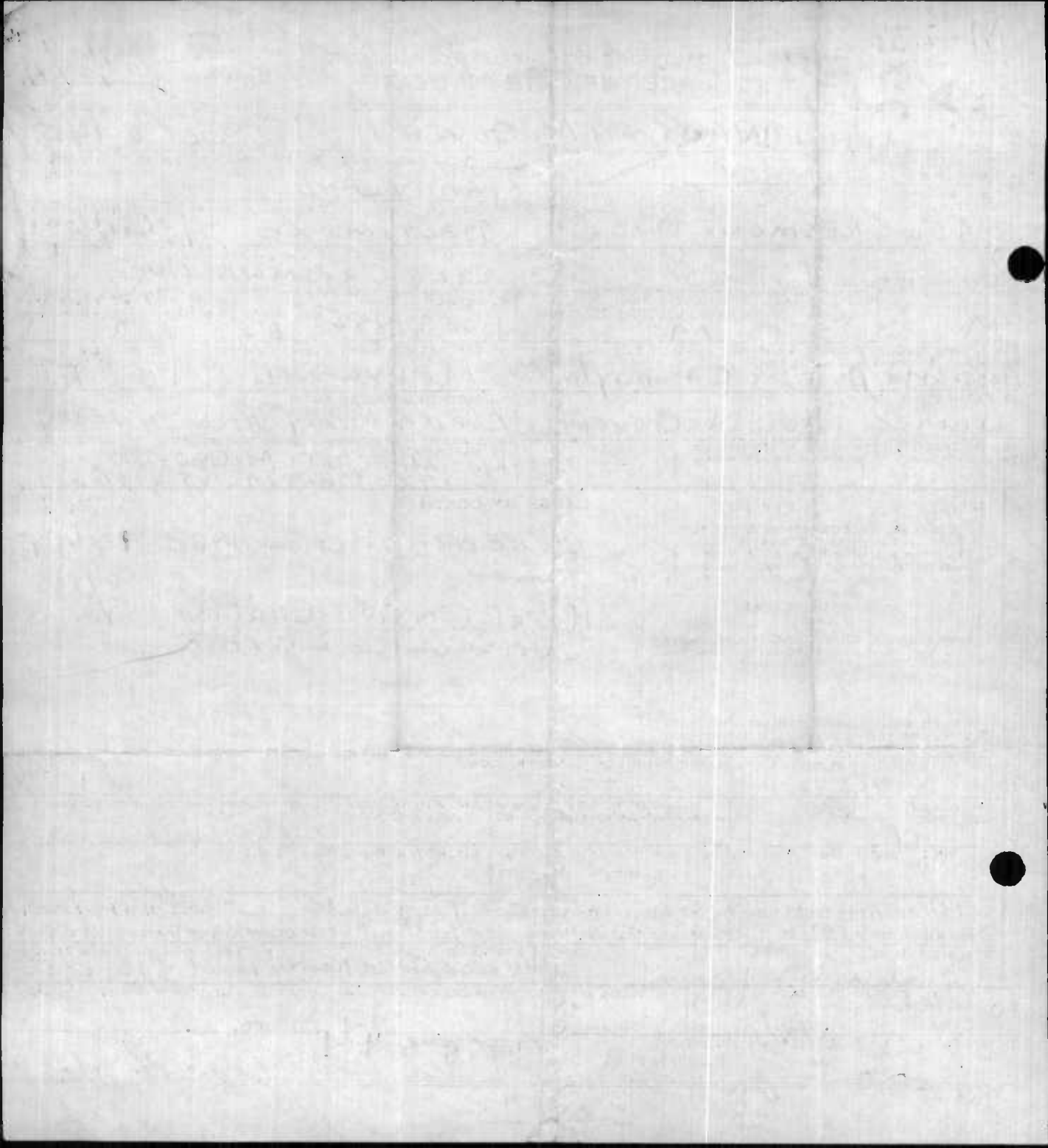
ADDRESS  
**1605 W. 11th St. Baltimore, Md.**

29073

093d

MEDICAL CERTIFICATION

Contact age is especially important



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 8612

BIRTH NO. 5-530

1. NAME OF DECEASED (Type or Print) <u>Major James Smith</u>		2. DATE OF DEATH <u>Oct. 5, '50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Ind.</u> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>JONES HOPKINS HOSPITAL</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore 3-01</u>	
D. STREET ADDRESS (If rural, give location) <u>1510 E. Lombard St</u>		E. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) _____	8. DATE OF BIRTH <u>12-28-86</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>ODD JOBS</u>	9. AGE (in years last birthday) <u>64</u>
13. FATHER'S NAME <u>Jordan Smith -</u>		12. CITIZEN OF WHAT COUNTRY? _____	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____ (If yes, give war or dates of service) _____		14. MOTHER'S MAIDEN NAME <u>P. Chadman</u>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>JONES HOPKINS HOSPITAL</u> ADDRESS _____	

18. <u>610x</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) <u>Urinary extravasation (operative) and shock (profound)</u> DUE TO _____ (B) <u>Cerebral vascular accident</u> DUE TO _____ (C) _____	INTERVAL BETWEEN ONSET AND DEATH <u>20 hours</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <u>4 Oct 50</u>	19B. MAJOR FINDINGS OF OPERATION <u>Enlarged prostate gland</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____
22. I hereby certify that I attended the deceased from <u>Sept. 28, 1960</u> to <u>Oct. 5, 1950</u> that I last saw the deceased alive on <u>Oct. 5, 1950</u> and that death occurred at <u>11:30 a.m.</u> , from the causes and on the date stated above.		
23A. SIGNATURE <u>A. Page Harris</u> M. D.	23B. ADDRESS <u>JONES HOPKINS HOSPITAL</u>	23C. DATE SIGNED <u>10-5-50</u>

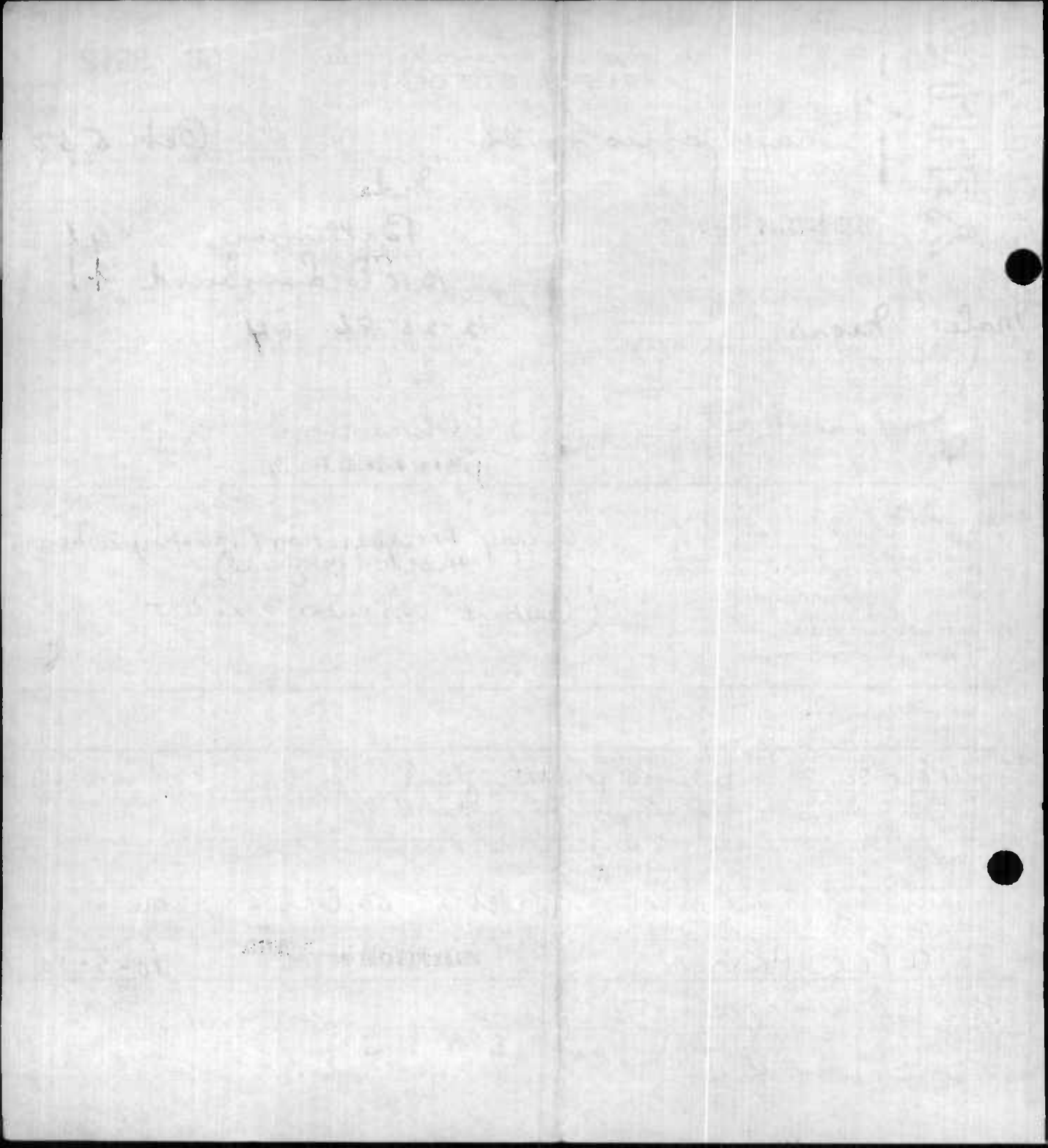
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10/8/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>	24D. LOCATION (City, town, or county) (State) <u>Satolund Ind.</u>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <u>Wm. H. Williams, M.D.</u>	FUNERAL DIRECTOR <u>Charles A. Rice</u>	ADDRESS <u>661 W. Barre St</u>

OCT 8 1950

97099

137a

MEDICAL CERTIFICATION





H-400

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

8613

BIRTH NO.

50 8613

1. NAME OF DECEASED  
(Type or Print)

Agnes Howley

2. DATE  
OF  
DEATH

10-5-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland, Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 24 1-02

D. STREET ADDRESS (If rural, give location)

508 S. Streeter St

c. Length of stay in Baltimore

42

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widow

8. DATE OF BIRTH

12-12-1881

9. AGE (In years,  
last birthday)

68

If Under 1 Year Months: Days  
If Under 24 Hours Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR  
INDUSTRY

AT HOME.

11. BIRTHPLACE (State or foreign country)

YORKSHIRE, ENGLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

2 TODD

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. JAMES HOWLEY 508 S. STREETER

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Uremia.

DUE TO

(B)

Churia.

DUE TO

(C)

Generalized abd. calc. no matosis.

INTERVAL BETWEEN  
ONSET AND DEATH

over

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from September 29, 1950, to 10-5, 1950, that I last saw the  
deceased alive on 10-5-1950, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

V. J. J. Velez

M. D.

23B. ADDRESS

1400 N. Caroline St

23C. DATE SIGNED

10-5-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

10-9-50

CATHEDRAL CEM

4300 OLD FREDERICK RD

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Charles S. Zeile, 901 S. Conowingo St.

JCT vs 8-1950

46B

correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

If possible, please state  
a more definite anatomical  
location of the malignant tumor?  
"Stomach"

See Document File 50 - 8613

10-18-50

70 20

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Emily E. Mullowney</i>		2. DATE OF DEATH <i>Oct 5, 1950</i> <i>12:10 Noon</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>4836 Park Heights Ave</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Balto.</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>4836 Park Heights Ave</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
C. Length of stay in Baltimore <i>about 11 yrs</i>		D. STREET ADDRESS (If rural, give location) <i>4836 Park Heights Ave</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Divorced</i>	8. DATE OF BIRTH <i>July 26, 1877</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	9. AGE (In years, last birthday) <i>73</i> If Under 1 Year: Months: Days: Hours: Min.
13. FATHER'S NAME <i>Penn</i>		11. BIRTHPLACE (State or foreign country) <i>Easton, Penn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>—</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
16. SOCIAL SECURITY NO. <i>—</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
17. INFORMANT <i>Mr. William E. Mullowney</i>		ADDRESS <i>807 Trade St. Rd.</i>	

<p>18. <i>420.1</i></p> <p><b>CAUSE OF DEATH</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>(A) <i>Coronary Heart Disease</i></p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>(B) <i>—</i></p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b></p> <p>(C) <i>—</i></p>	<p>INTERVAL BETWEEN ONSET AND DEATH <i>Oct 2, 1950</i></p>

19A. DATE OF OPERATION <i>—</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>October 2</i> , 19 <i>50</i> , to <i>October 5</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Oct 5</i> , 19 <i>50</i> , and that death occurred at <i>12:10 P.</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>John St. Aubert</i>		23B. ADDRESS <i>4803 Park Heights Ave</i>		23C. DATE SIGNED <i>Oct 7, 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Oct 9/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Easton Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Easton, Pa</i>		
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>Thurston Williams, M.D.</i>	25. FUNERAL DIRECTOR <i>Loring Byers</i>		ADDRESS <i>5005 Park Heights Ave</i>	

OCT - 9 1950

094a

RECEIVED 17 JUL 1964

FROM: SAC, NEW YORK

TO: DIRECTOR, FBI

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

BY: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

21. [illegible]

22. [illegible]

23. [illegible]

24. [illegible]

25. [illegible]

26. [illegible]

27. [illegible]

28. [illegible]

29. [illegible]

30. [illegible]

31. [illegible]

32. [illegible]

33. [illegible]

34. [illegible]

35. [illegible]

36. [illegible]

37. [illegible]

38. [illegible]

39. [illegible]

40. [illegible]

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

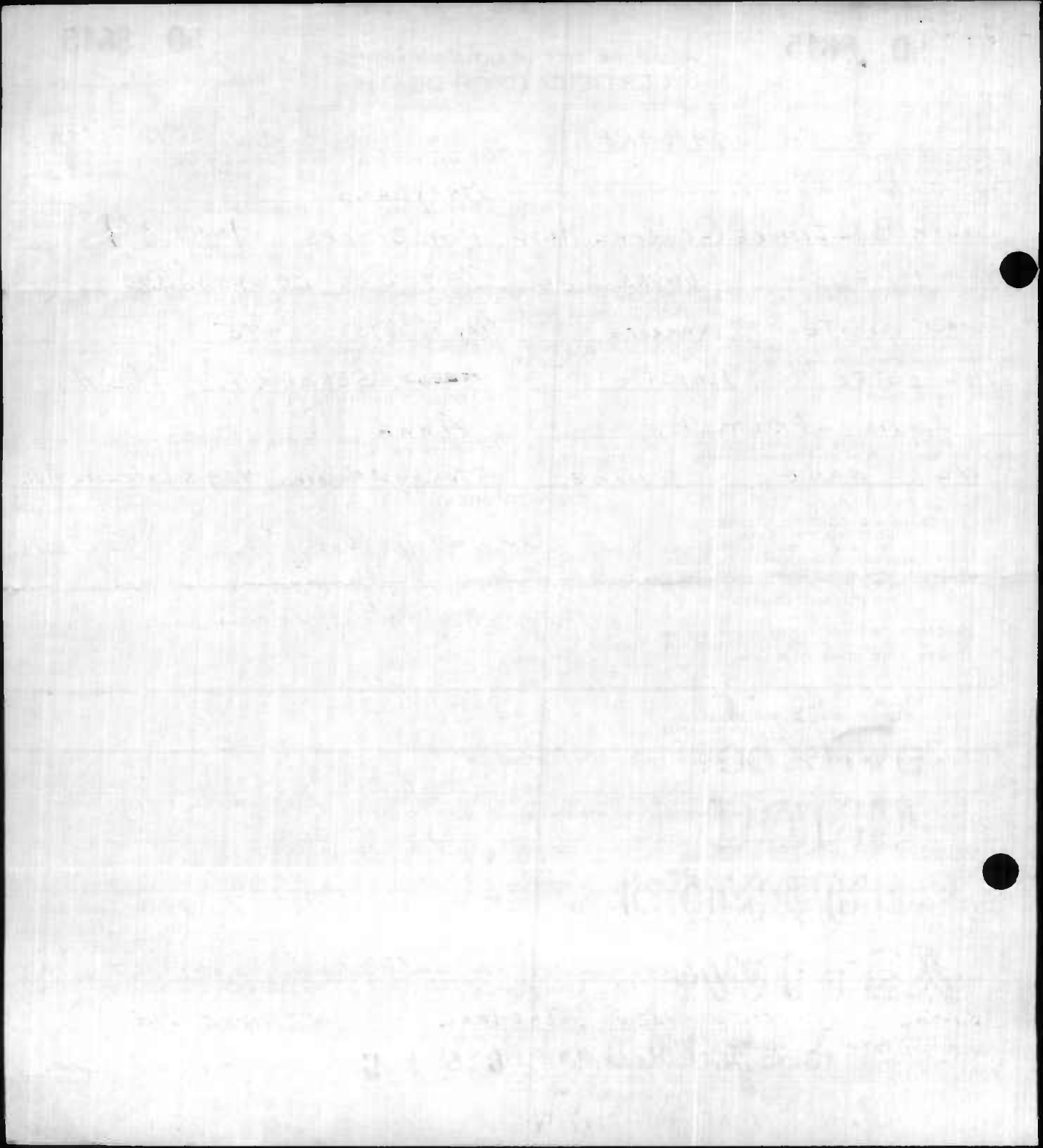
1. NAME OF DECEASED (Type or Print) <b>ANNA MAKARES</b>		2. DATE OF DEATH <b>OCT. 7, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>South BALTIMORE GENERAL HOSP.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 1-03</b>	
Length of stay in Baltimore <b>66 YRS.</b>		D. STREET ADDRESS (If rural, give location) <b>729 S. LAKEWOOD AVE</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>MAY 18, 1875</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
13. FATHER'S NAME <b>Louis Strumsky</b>		14. MOTHER'S MAIDEN NAME <b>Anna ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Stanley V. Makares</b>		ADDRESS <b>729 S. LAKEWOOD AVE</b>	

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Coronary artery disease</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>10-10-50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Oct. 4, 1950</b> to <b>Oct. 7, 1950</b> , that I last saw the deceased alive on <b>Oct. 7, 1950</b> , and that death occurred at <b>8:35 a.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Martin C. Macapanpan, M.D.</b>		23B. ADDRESS <b>501 Balto. Gen. Hosp.</b>		23C. DATE SIGNED <b>Oct. 8, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-10-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>	
24D. LOCATION (City, town, or county) <b>BALTIMORE, Md.</b>		24E. FUNERAL DIRECTOR <b>Geo. L. Kestel</b>		24F. ADDRESS <b>2101 Frederick Ave.</b>	

**MARTIN C. MACAPANPAN**

094a





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>ROBERT M. HOWIE</b>		2. DATE OF DEATH <b>Oct. 7, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Franklin Square Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>20-04</b>	
D. STREET ADDRESS (If rural, give location) <b>2519 Hollins St.</b>		5. LENGTH OF STAY IN BALTIMORE <b>44 yrs.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 12, 1883</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		9. AGE (In years last birthday) <b>67</b>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Scotland</b>	
13. FATHER'S NAME <b>George Howie</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>1</b>		16. SOCIAL SECURITY NO. <b>213-03-8456</b>	
17. INFORMANT <b>Mrs. Alice Howie</b>		ADDRESS <b>2519 Hollins St.</b>	

18. <b>E902.3</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Intracerebral hemorrhage</b> DUE TO <b>(B) Skull fracture with subdural hemorrhage</b> DUE TO <b>(C)</b>		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Public</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Hilton &amp; Baltimore St. 20/7</b>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>Oct. 6, 1950 &amp; 11 A.M.</b>		21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell from scaffold to ground</b>
22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .				
23A. SIGNATURE <b>William V. L...</b>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.		23C. DATE SIGNED <b>Oct. 7, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Oct. 10, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>bu don Park</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>Oct. 9, 1950</b>		REGISTRAR'S SIGNATURE <b>Harry H. Witzke</b>		25. FUNERAL DIRECTOR'S ADDRESS <b>Harry H. Witzke 4101 Edmondson Ave.</b>



K-400

50 8617

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 8617

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FREDERICK KELLY

2. DATE  
OF  
DEATH

October 6, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR US Marine Hospital  
INSTITUTION Wyman Pk. Drive & 31st St.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 12-06D. STREET ADDRESS (If rural, give location)  
2613 Maryland Ave.

c. Length of stay in Baltimore ?

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

11/8/90

9. AGE (In years  
last birthday)

59

10 Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
Carpenter10B. KIND OF BUSINESS OR  
INDUSTRY11. BIRTHPLACE (State or foreign country)  
Iowa12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

Louis Kelly

14. MOTHER'S MAIDEN NAME  
Ella ?15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
Yes WWI - USA16. SOCIAL  
SECURITY NO.  
?17. INFORMANT ADDRESS  
Records- US Marine Hospital, Balto, Md.

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Chronic glomerulonephritis with  
uremia

DUE TO

Unknown

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Peripheral arteriosclerosis

DUE TO

Unknown

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Osteomyelitis chronic, left femur

Several  
yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 3, 1950, to Oct. 6, 1950, that I last saw the deceased alive on Oct. 6, 1950, and that death occurred at 5:05 A. M., from the causes and on the date stated above.

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK AT WORK23A. SIGNATURE  
John L. Wilson, Medical Director23B. ADDRESS  
US Marine Hospital, Balto, Md.23C. DATE SIGNED  
10/6/5024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Oct. 9/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National

24D. LOCATION (City, town, or county)

5501 Frederick Rd. Balto. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT-9-1950

Thurston Williams

Harry A. Lutzke

4101 Edmondson

VS 150

AV.

51024

1316

\_\_\_\_\_







50 8619

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8619  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frederick G. Boardman

2. DATE  
OF  
DEATH

Oct. 6/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

14 S. Catherine St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

20-04

D. STREET ADDRESS (If rural, give location)

14 S. Catherine St.

c. Length of stay in Baltimore

32 yrs

5. SEX

Male

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

Widowed

8. DATE OF BIRTH

Sept. 11, 1878-79

9. AGE (in years last birthday)

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR INDUSTRY

Sanitary Laundry

11. BIRTHPLACE (State or foreign country)

Canada

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Boardman

14. MOTHER'S MAIDEN NAME

----Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

412 16 5101 A

17. INFORMANT

ADDRESS

Mrs. Ethel Culp, 14 S. Catherine St

18. 304x

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senility with senile dementia

6 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER- Lying ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE ☐ WORK AT WORK

22. I hereby certify that I attended the deceased from Oct. 1, 1950, to Oct. 6, 1950, that I last saw the deceased alive on Oct. 5, 1950, and that death occurred at 3:50 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Oct. 9/50

Lorraine Pk.

Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

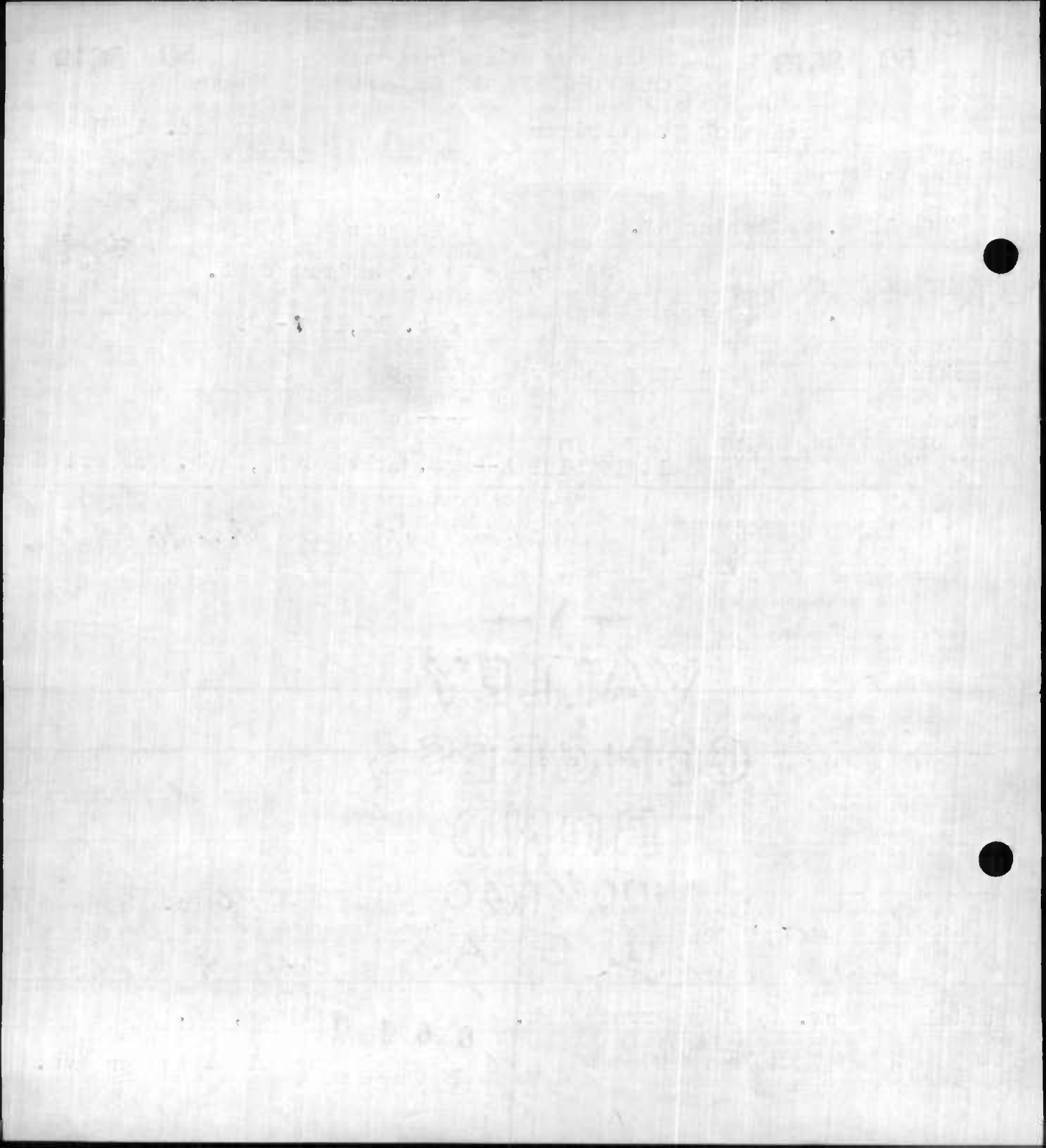
ADDRESS

OCT - 9 1950

Huntington Williams, M.D.

Harry A. Witzke

4101 Edmondson Ave.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. 50-21401

1. NAME OF DECEASED (Type or Print) <u>Jerome Pierce Myers</u>			2. DATE OF DEATH <u>Oct 7, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution location) <u>Hospital for the Women of Md</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Balto-5</u>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <u>1251 Frailey Way.</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>Oct 2 1950</u>	9. AGE (In years, last birthday) <u>5</u>	If Under 1 Year: Days _____ Hours _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Pierce Albert Myers</u>			14. MOTHER'S MAIDEN NAME <u>Virginia Kathleen Benfield</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Mother.</u>		

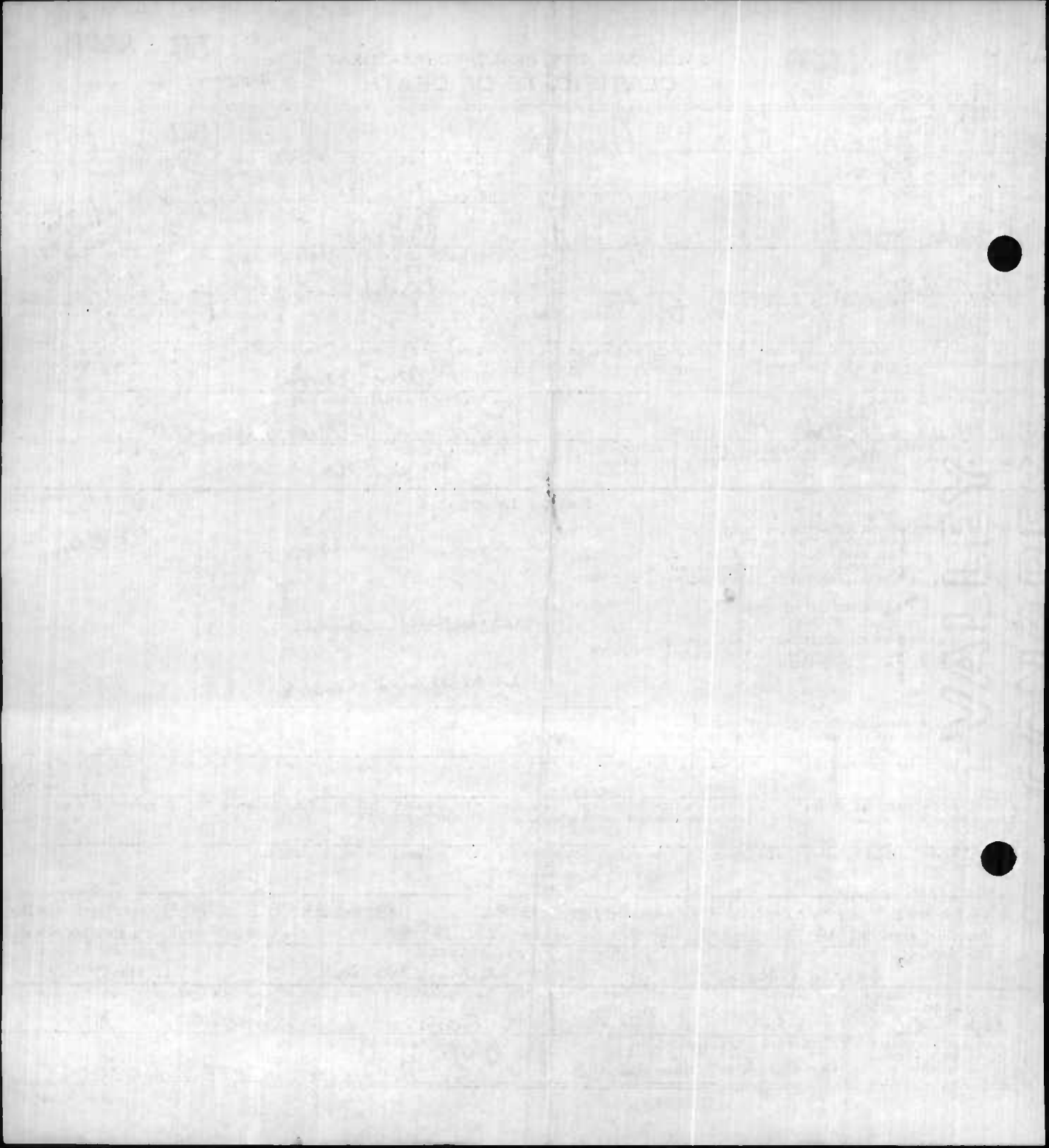
18. <u>760.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <u>Cerebral Hemorrhage -</u> DUE TO (B) <u>Undetermined cause</u> DUE TO <u>Undetermined Cause.</u> (C) <u>none</u>	INTERVAL BETWEEN ONSET AND DEATH <u>5 days.</u>
--	--	--

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 10-2- 1950, to 10-7, 1950, that I last saw the deceased alive on 10-7, 1950, and that death occurred at 10:50 A. m., from the causes and on the date stated above.

23A. SIGNATURE <u>Lucas D. Rocca</u>	M. D.	23B. ADDRESS <u>Women's Hospital</u>	23C. DATE SIGNED <u>10-17-50</u>
---	-------	---	-------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	24B. DATE <u>10/9/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>OCT - 9 1950</u>	REGISTRAR'S SIGNATURE <u>Thurston Williams, M.D.</u>	25. FUNERAL DIRECTOR ADDRESS <u>John J. Moran - 3000 E. Balt. St</u> <u>ABR</u>	



000 50 8621

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8621

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CLARA DAY

2. DATE  
OF  
DEATH

10/5/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 4600 Sorentino Rd.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Colonial Nursing Home

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housework

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

13. FATHER'S NAME

Gottlieb Kiefer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)  
A. STATE  
Md.

B. COUNTY

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

614 Woods Street

8. DATE OF BIRTH

4/28/1877

9. AGE (In years  
last birthday)

73

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Marie

?

17. INFORMANT

ADDRESS

Family - Same

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TOHypertensive Cardio-  
Vascular Heart Disease  
Atherosclerosis

ANTECEDENT CAUSES

(B) .....  
DUE TO  
(C) .....

Myocardial Failure

year.  
3 days.II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-3 150, to 10-5 150, 1950, that I last saw the  
deceased alive on 10-5 1950, and that death occurred at 2 P M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Wilbur L. Flannery

M. D.

3025 Belair Road

10-9-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

B

24B. DATE

10/9/50

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT-9-1950

Huntington Williams, M.D.

James H. Williams

- 130 E. Fort Ave.

VS 150

093d

MEDICAL CERTIFICATION

82-6456



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Charles Green</b>			2. DATE OF DEATH <b>Oct 5, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Sinai Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital of Baltimore Inc</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>DUNDALK 5240</b>		
c. Length of stay in Baltimore <b>LIFE</b>			D. STREET ADDRESS (If rural, give location) <b>3 ARROWSHIP RD.</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	B. DATE OF BIRTH <b>MARCH 25, 1916</b>		9. AGE (In years last birthday) <b>74</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST (RET)</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>BETH STEEL CO.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO. CO., MD.</b>
13. FATHER'S NAME <b>CHARLES A. GREEN</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No.</b>			16. SOCIAL SECURITY NO. <b>216-10-389</b>		
17. INFORMANT <b>CHAS. H. GREEN</b>			ADDRESS <b>5 F. ARROWSHIP RD.</b>		

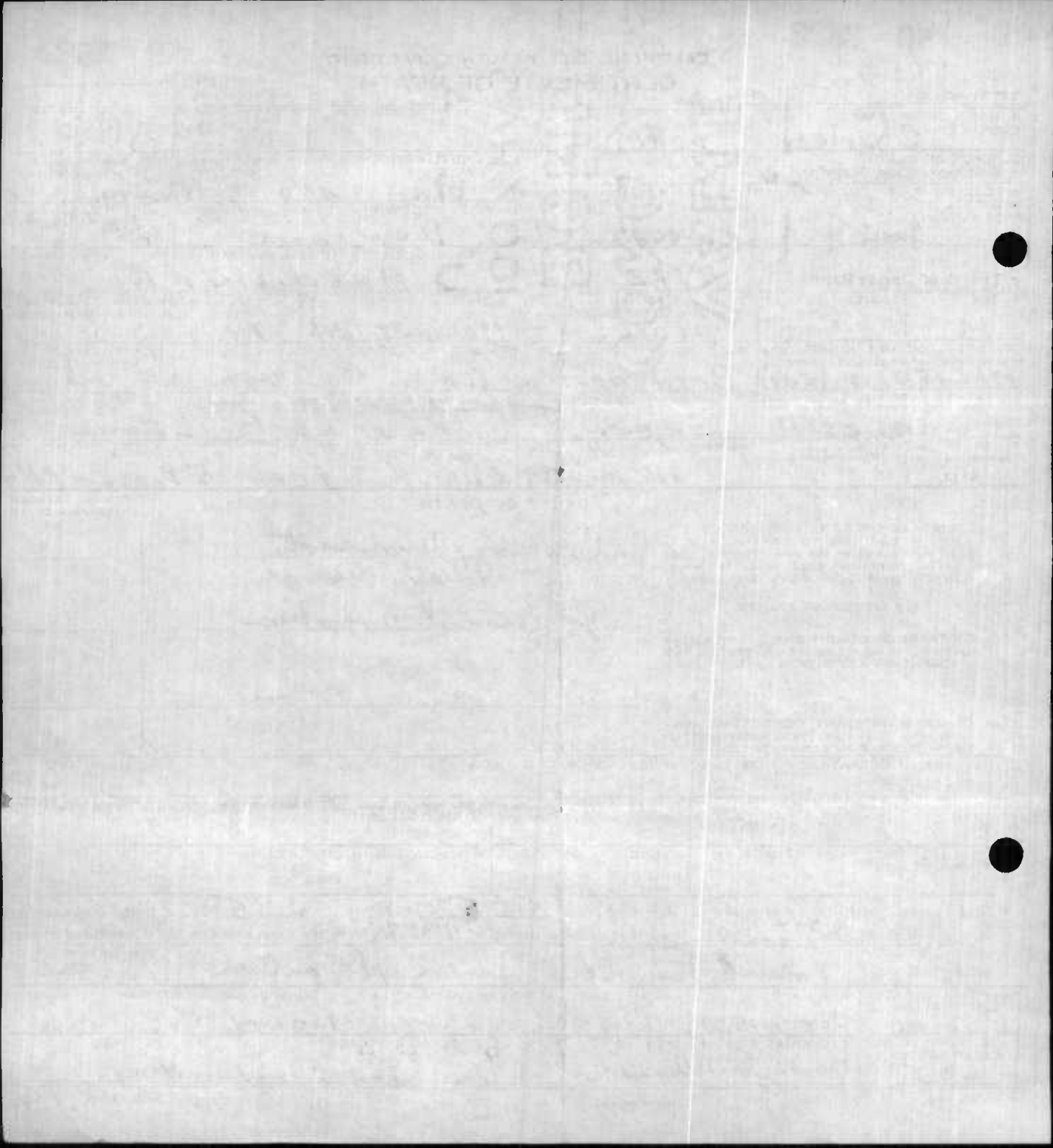
18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH  (A) <b>Coronary arteriosclerotic heart disease</b> DUE TO  (B) <b>Rt femoral embolus</b> DUE TO  (C) _____	INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Oct 5, 1950**, to **Oct 5, 1950**, that I last saw the deceased alive on **Oct 5, 1950**, and that death occurred at **11:35 AM** from the causes and on the date stated above.

23A. SIGNATURE <b>Joseph Louis Feingold</b>		23B. ADDRESS <b>Sinai Hospital</b>		23C. DATE SIGNED <b>10-5-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>OCT. 9, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. CO. MD.</b>		24E. FUNERAL DIRECTOR <b>WILLIAM H. WILLIAMS</b>		ADDRESS <b>DUNDALK, MD.</b>	

DATE RECEIVED BY LOCAL REGISTRAR **OCT-9-1950**  
REGISTRAR'S SIGNATURE **WILLIAM H. WILLIAMS**  
FUNERAL HOME **WILLIAM H. WILLIAMS**  
VS 150  
**5443U**  
**938**



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

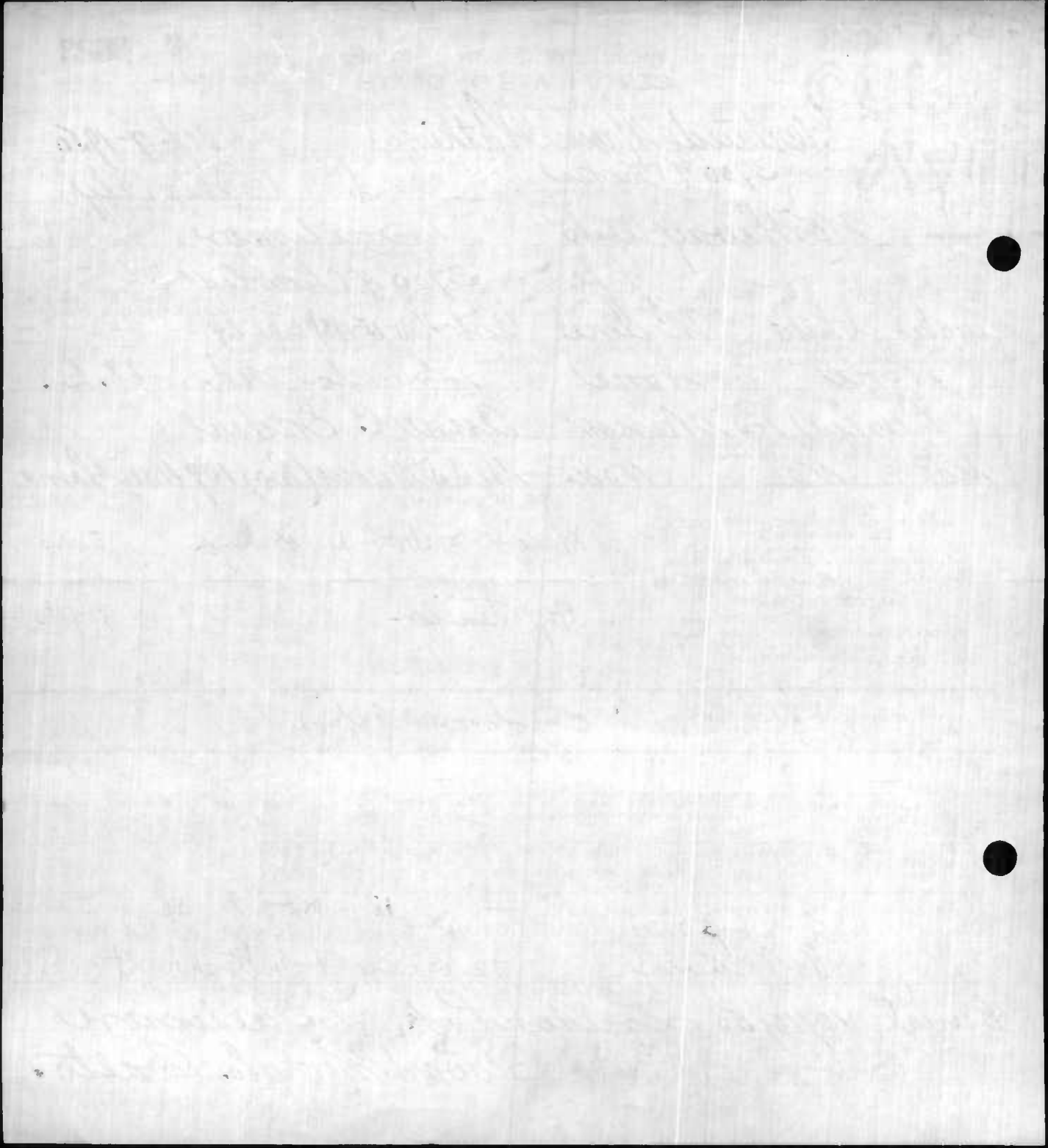
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Gertrude Mann Watkins</i>		2. DATE OF DEATH <i>Oct-7-1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>3700 7<sup>th</sup> Charles</i>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Balto City</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Northway Apts</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 12-01</i>	
c. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>3700 7<sup>th</sup> Charles St -</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Oct-7-1900-15-188</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
13. FATHER'S NAME <i>Charles B Mann</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Mrs S P Mann (bro)</i>		ADDRESS <i>109 Hawthorne</i>	

18. <i>331X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) <i>massive cerebral hemorrhage</i> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <i>5 hrs</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) <i>Hypertension</i> DUE TO	<i>9 yrs</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Osteoporosis of spine</i>		

19A. DATE OF OPERATION _____		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 19 <i>48</i> , to <i>Oct 7</i> , 1950, that I last saw the deceased alive on <i>Oct 7</i> , 1950, and that death occurred at <i>1:30</i> p. m., from the causes and on the date stated above.					
23A. SIGNATURE <i>John A. Lutzcher</i>		23B. ADDRESS <i>12 E. Eager St - Balto 2nd</i>		23C. DATE SIGNED <i>OCT 9, 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/10/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Louison Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>		25. FUNERAL DIRECTOR <i>Stewart Morris</i>		ADDRESS <i>Balto.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT-9-1950</i>		REGISTRAR'S SIGNATURE <i>H. J. Williams</i>			



100  
50 8624BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8624

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MR. JESSE L. WEBB

2. DATE  
OF  
DEATH

OCT. 6, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION UNION MEMORIAL HOSPITAL4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
B. COUNTY

MD.

BALTIMORE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
PIKESVILLE

D. STREET ADDRESS (If rural, give location)

610 UPLAND RD.

5300

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

FEB. 4, 1896

9. AGE (In years  
last birthday)

54

11 Under 1 Year  
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
OFFICE (INSURANCE)10B. KIND OF BUSINESS OR  
INDUSTRY  
INSURANCE

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

OSCAR E. WEBB

14. MOTHER'S MAIDEN NAME

GRACE CASSARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

UNK.

(If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

219-05-9393

17. INFORMANT

DECEASED

ADDRESS

1B. 442X.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Tremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Thrombosis Renal arteries

DUE TO

(C)

Hypertensive Cardiovascular  
DiseaseII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JULY 2, 1950, to OCT. 6, 1950, that I last saw the  
deceased alive on OCT. 6, 1950, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Francis H. Warr

M. D.

23B. ADDRESS

Union Memorial Hosp.

23C. DATE SIGNED

10-6-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

October-9-50

24C. NAME OF CEMETERY OR CREMATORY

Greenmount

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT - 9 1950

Huntington Memorial Hosp.

846  
Steward & Mowbray Co.

108 W. North Ave.

VS 150

450 73

City #1. 937

MEDICAL CERTIFICATION



or

100

100

100

7

100

100

100

100

100



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Mrs. FRANCES DOUGHERTY</b>		2. DATE OF DEATH <b>OCT. 6, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>BOW SECOURS HOSP.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE, 16-05</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>512 LYNDBURST ST.</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>9/16/26</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) <b>24</b>
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <i>John Tighe</i>		14. MOTHER'S MAIDEN NAME <i>Cecelia Craning</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Mrs. Thomas F. Dougherty</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		ADDRESS <i>504 Charming Lane Rd.</i>	

18. <b>672X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH  (A) <b>SHOCK</b> DUE TO  (B) <b>Hemorrhage</b> DUE TO  (C) <b>Hemorrhagic diathesis 8th?</b> <b>PREGNANCY - DELIVERED - 10/6/50</b>	INTERVAL BETWEEN ONSET AND DEATH  <b>7 1/2 hrs.</b>          <b>over</b>
--	--	--

19A. DATE OF OPERATION <b>10/6/50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **10/6**, 19**50**, to **10/6**, 19**50** that I last saw the deceased alive on **10/6/1950** and that death occurred at **6:25 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE <i>John K. Mullen</i>	23B. ADDRESS <b>Bow Secours Hosp.</b>	23C. DATE SIGNED <b>10/6/50</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Oct 10/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Cathedral</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT - 9 1950</b>	REGISTRAR'S SIGNATURE <i>Wm. J. Williams, M.D.</i>	25. FUNERAL DIRECTOR <b>Stewart &amp; Mowen Co. 108-W North Ave.</b>	

Birth - 50-22947 - 10/6/50

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

DAISY B. WILLIAMS

2. DATE OF DEATH  
Oct. 6, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION Doctor's Hosp.4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Md.  
B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 16-05D. STREET ADDRESS (If rural, give location)  
2404 Arunah Ave.

c. Length of stay in Baltimore

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

July 10, 1890

9. AGE (In years, last birthday)

60

If Under 1 Year: Months: Days  
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Engle

14. MOTHER'S MAIDEN NAME

Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Mr. Robert P. Williams 2404 Arunah Ave.

18. 442x

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(A) Respiratory Failure

DUE TO

(B) Hypertensive & Atherosclerotic Cardiovascular Disease

DUE TO

(C) Arrhythmia, Fibrillation & release of multiple emboli

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from June 1946 to Oct 6, 1950, that I last saw the deceased alive on Oct 6, 1950, and that death occurred at 8:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/9/50

24C. NAME OF CEMETERY OR CREMATORY

Pine Grove Cem.

24D. LOCATION (City, town, or county)

Mt. Airy, Md.

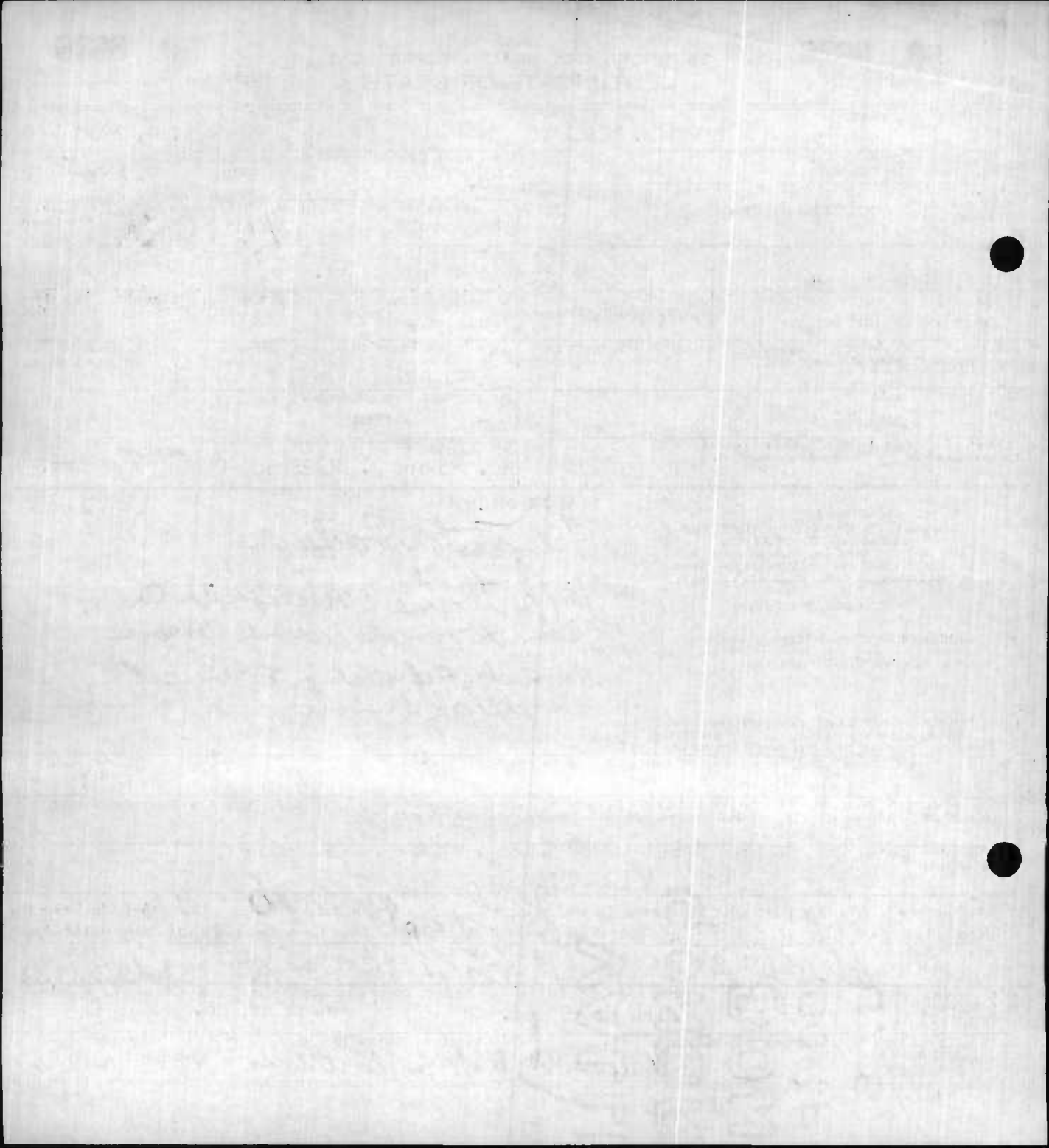
(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

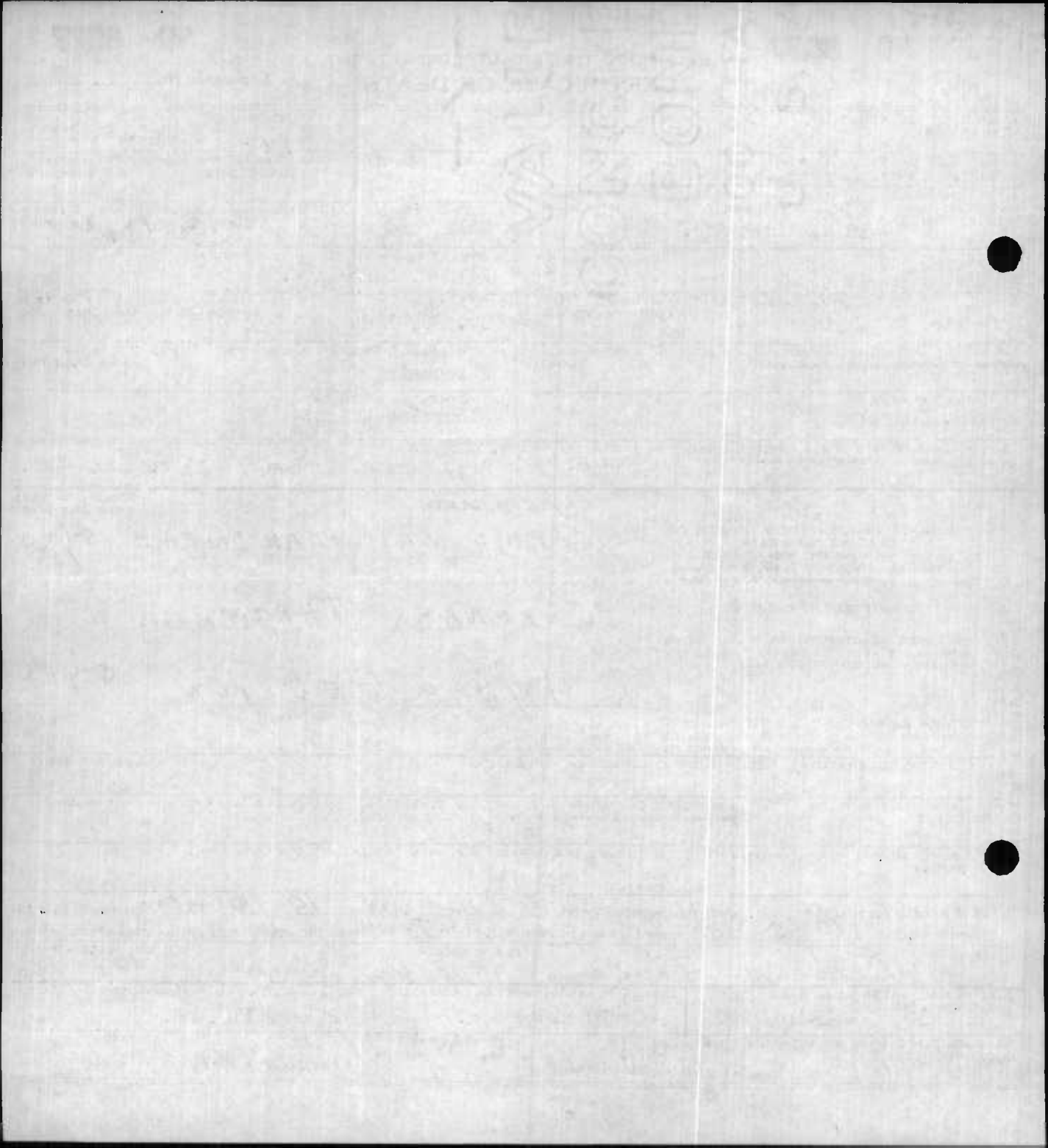
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>EMMA C. DOBSON</b>			2. DATE OF DEATH <b>Oct. 6, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>2419 W. North Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>2419 W. North Ave.</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>Nov. 20, 1885</b>		9. AGE (In years, last birthday) <b>64</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Wm. Dudeck</b>			14. MOTHER'S MAIDEN NAME <b>Albertine Knight</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT ADDRESS <b>Mrs. Emma C. Dobson 2419 W. North Ave.</b>		

<p>18. <b>420.1</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p align="center"><b>CAUSE OF DEATH</b></p> <p>(A) <b>CARDIO VASCULAR DISEASE</b> 5 YRS</p> <p align="center">DUE TO</p> <p>(B) <b>CORONARY THROMBOSIS</b></p> <p align="center">DUE TO</p> <p>(C) <b>HYPERTENSION</b> 5 YRS.</p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p>

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>6/10/1945</b> to <b>10/6/1950</b> , that I last saw the deceased alive on <b>10/5/1950</b> , and that death occurred at <b>4 P.</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>William Frey</b>		23B. ADDRESS <b>1728 Penna Ave</b>		23C. DATE SIGNED <b>10/7/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/10/1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>		

DATE RECEIVED BY LOCAL REGISTRAR <b>OCT-9-1950</b>	REGISTRAR'S SIGNATURE <b>Thurston Williams, Md</b>	FEDERAL DIRECTOR <b>Wm. J. Pickner &amp; Sons - Balt</b>	ADDRESS <b>Md.</b>
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410

50 8628

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

50 8628

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARGARET A WOLFF

2. DATE  
OF  
DEATH

10/7/50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Mercy Hospital

c. Length of stay in Baltimore

Life

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

9-08

d. STREET ADDRESS (If rural, give location)

507 E. 23d. St.

8. DATE OF BIRTH

Dec 3, 1874

9. AGE (In years,  
last birthday)

75

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR  
INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Carey

14. MOTHER'S MAIDEN NAME

Sarah Curran

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

Charles Wolff Sykesville Md.

18. 153X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Carcinoma of lower sigmoid Colon

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Congestive Heart Failure

8 hrs.

19a. DATE OF OPERATION

10/6/50

19b. MAJOR FINDINGS OF OPERATION

Carcinoma of lower sigmoid Colon

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 6, 1950, to Oct. 7, 1950, that I last saw the deceased alive on Oct. 7, 1950, and that death occurred at 10:50 A.m., from the causes and on the date stated above.

23a. SIGNATURE

W. B. Keever, Jr. M. D.

23b. ADDRESS

Mercy Hosp.

23c. DATE SIGNED

10/7/50

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24b. DATE

10/10/50

24c. NAME OF CEMETERY OR CREMATORY

New Cathedral

24d. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

Wm. J. Vickers &amp; Sons - Balt.

ADDRESS

Baltimore, Md.

1917

CERTIFICATE OF DEATH

State of New York

County of New York

City of New York

On this day of

1917

at New York

I, the undersigned

do hereby certify that

the within and foregoing

is a true and correct

statement of the facts

and circumstances

surrounding the death

of the person named

in the foregoing

certificate.

Witness my hand and seal

this day of

600

1962

50 8629

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8629

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Hattie Mae Murray

2. DATE  
OF  
DEATH

October 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR INSTITUTE location)Baltimore City Hospitals  
4940 Eastern AvenueC. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

11-03

c. Length of stay in Baltimore

6 Years

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

226 W. Chase St.

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec. 25, 1917

9. AGE (In years)

32

(birthday)

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Otis Brown

14. MOTHER'S MAIDEN NAME

Mamie Lou Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT  
Baltimore City Hospitals  
Records- 4940 Eastern Avenue

18. 491X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Bronchial Pneumonia

DUE TO

4 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 25, 1950, to Oct. 5, 1950, that I last saw the  
deceased alive on Oct. 5, 1950 and that death occurred at 1 AM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

10-5-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT-9-1950

Huntington Williams, Jr.

Metraucis A. Hemley Biddle St.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>PETER SNEAD</b>		2. DATE OF DEATH <b>October 4, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>South Baltimore General Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>23-01</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>1029 Reach Alley</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>10/1/1896</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Junk Dealer</b>	9. AGE (In years last birthday) <b>54</b>
13. FATHER'S NAME <b>Peter B. Snead</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		12. CITIZEN OF WHAT COUNTRY? _____	
16. SOCIAL SECURITY NO. <b>None</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
17. INFORMANT <b>Frank Johnson-1029 Peach Street</b>		ADDRESS _____	

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
(B) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>William V. [Signature]</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	23C. DATE SIGNED <b>Oct. 4, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/9/1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>A.A.Co., Md.</b>

DATE RECEIVED BY LOCAL REGISTRAR <b>OCT-9-1950</b>	SIGNATURE OF REGISTRAR <i>[Signature]</i>	25. FUNERAL DIRECTOR <b>J. L. Brown &amp; Son - Montgomery</b>	ADDRESS <b>1082</b>
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29068

0932

MEDICAL CERTIFICATION

Correct age is especially important. Infants - please write the cause of death clearly and legibly.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

1920

1920

1920

NAME

SEX

AGE

DATE

PLACE

TIME

CAUSE

AND

CAUSE OF DEATH

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CAUSE OF DEATH

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CAUSE OF DEATH

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 8631

BIRTH NO. 261 50 8631

1. NAME OF DECEASED (Type or Print) <u>Marjorie Gail Skirboll</u>			2. DATE OF DEATH <u>Oct. 8, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <u>3125 Hanlon Ave.</u> <b>K5-37</b>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 18, 1943</u>		9. AGE (In years last birthday) <u>7</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Maurice Skirboll</u>			14. MOTHER'S MAIDEN NAME <u>Eunice Rothman</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Maurice Skirboll 3125 Hanlon Ave</u>		

18. <u>193x</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Medulloblastoma</u> DUE TO <u>the tumor to lung, liver</u>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <u>0</u>		
19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>June 18, 1950</u> , to <u>Oct. 8, 1950</u> that I last saw the deceased alive on <u>Oct. 8, 1950</u> , and that death occurred at <u>4:30 pm.</u> , from the causes and on the date stated above.		
23A. SIGNATURE <u>A. Andrew Celecca</u>	23B. ADDRESS <u>11400 N. Caroline St.</u>	23C. DATE SIGNED <u>Oct. 8, 1950</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>October 10, 1950</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Hebrew Herring Run Cemetery Baltimore Md</u>
24D. LOCATION (City, town, or county) <u>Baltimore</u>	25. FUNERAL DIRECTOR ADDRESS <u>1126 Sol Lukensont Bus W North ave</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>OCT - 9 1950</u>	REGISTRAR'S SIGNATURE <u>William M. Williams</u>	

1740

07

WASHINGTON, D.C. 20540

1740

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

5-34  
AB-112313

50 8632

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8632

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary Vendelis

2. DATE  
OF  
DEATH

Oct. 7-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTEBaltimore City Hospitals  
4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

26-05

D. STREET ADDRESS (If rural, give location)

500 Rapolla St. Rapolla

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

March 28-1931

9. AGE (In years last birthday)

19

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

AT HOME

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Andrew Vendelis

14. MOTHER'S MAIDEN NAME

Despina Apostolakis

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT Baltimore City Hospitals  
Records: 4940 Eastern Ave.

18. 416X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema

DUE TO

5 min.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Rheumatic Heart Disease

DUE TO

Over 2 yrs.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-7-\_\_\_\_, 1950 to 10-7-\_\_\_\_, 1950, that I last saw the deceased alive on 10-7-\_\_\_\_, 1950, and that death occurred at 7 A. m., from the causes and on the date stated above.

23A. SIGNATURE

M. Cohen

23B. ADDRESS Baltimore City Hospitals

M. D. 4940 Eastern Ave.

23C. DATE SIGNED

10-7-1950

24A. (BURIAL) CREMA-  
TION, REMOVAL (Specify)

24B. DATE

10-9-50

24C. NAME OF CEMETERY OR CREMATORY

Greek Cemetery

24D. LOCATION (City, town, or county)

Winchester Mill Rd.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

OCT-9-1950

25. FUNERAL DIRECTOR

ADDRESS

Lambert Mc 440 E North Ave

Was the RH condition  
accompanied by active  
rheumatic fever at the time of death?

Do clinic records  
show particular type?

"Inactive"

See Document File 50-8637

11-10-50

Es.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 8633

BIRTH NO. 36 50 8633

1. NAME OF DECEASED  
(Type or Print)

Elizabeth (Smith) Smithers

2. DATE OF

DEATH Oct. 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

1521 N. Gilmore St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1521 N. Gilmore St.

C. Length of stay in Baltimore

56 years

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

June 10, 1871

9. AGE (In years last birthday)

79

10 Under 1 Year  
Months: Days

11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

Pvt. family

11. BIRTHPLACE (State or foreign country)

Harriett Co. Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry Smithers

14. MOTHER'S MAIDEN NAME

Eliza Scott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.  
None

17. INFORMANT

ADDRESS

Mrs. Ruth Richardson 802 McKean Ave.

18. 422.1

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. Scott

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

Oct. 6, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/9/1950

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Pk.

24D. LOCATION (City, town, or county)

Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL HOME

Antonia Funeral Home  
1631 Druid Hill Ave.

OCT - 9 1950

VS 151

0932

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 8634

BIRTH NO. 48-20740

1. NAME OF DECEASED  
(Type or Print)

NATHANIEL

MOLLOCK

2. DATE  
OF  
DEATH

October 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Mercy Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 5-02

D. STREET ADDRESS (If rural, give location)

413 Forrest Street

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Sept. 21, 1948

9. AGE (In years  
last birthday)

2

# Under 1 Year  
Months: Days

# Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

13. FATHER'S NAME

James Usken

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Eldora Mollock

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Eldora Mollock 413 Forrest St., Balt., Md.

18. E 812.0

**CAUSE OF DEATH**

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) Rupture of liver

**ANTECEDENT CAUSES**

(B) Intraperitoneal hemorrhage

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Forrest and Low Streets

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

October 5, 1950 3:45 P.M.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Struck by a Tutti-Frutti ice cream truck

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. Ford

23B. CHIEF MEDICAL EXAMINER.....☐

ASSISTANT MEDICAL EXAMINER.....☒

23C. DATE SIGNED

October 6, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 9, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Mt. Winder, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

OCT - 9 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Charles H. Alexander 1200 Melrose

ADDRESS

Baltimore, Md.

MEDICAL CERTIFICATION



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print) **Roy Lester Hutcherson**

2. DATE OF DEATH **October 7, 1950**

3. PLACE OF DEATH:  
A. **Baltimore City, Maryland**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Md.** B. COUNTY **Baltimore**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
**U.S. Marine Hospital, Baltimore, Md.**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore, Md.**

c. Length of stay in Baltimore **unknown**  
Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location)  
**Rt. 16, Box 66, Richter Trailer Park**

5. SEX **male** 6. COLOR OR RACE **white** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **married**

8. DATE OF BIRTH **Apr 22, 1901** 9. AGE (In years last birthday) **49** 10 Under 1 Year Months Days 11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**Coast Guard RETIRED**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
**Tennessee**

12. CITIZEN OF WHAT COUNTRY?  
**USA**

13. FATHER'S NAME  
**Ed Hutcherson**

14. MOTHER'S MAIDEN NAME  
**Ada Nickelson**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **yes** (If yes, give war or dates of service) **unknown**

16. SOCIAL SECURITY NO.  
**unknown**

17. INFORMANT ADDRESS  
**Records, U.S. Marine Hospital, Balto. Md.**

18. **466x**

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Infarction Pulmonary**

**Several Days**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO **Thrombosis of Vena Cava**  
(B) **following pneumonia**  
DUE TO **acute left lung**

**2 Weeks**

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **none** 19B. MAJOR FINDINGS OF OPERATION **none**

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) **none**

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) **none**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **9/23/50**, 19**50**, to **10/7/50**, 19**50**, that I last saw the deceased alive on **10/7/50** and that death occurred at **10:55 am** from the causes and on the date stated above.

23A. SIGNATURE **John L. Wilson, Med Director, Clinical Director U.S. Marine Hospital, Balto.** 23B. ADDRESS **1091** 23C. DATE SIGNED **10/5/50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **Oct 12, 1950** 24C. NAME OF CEMETERY OR CREMATORY **Memorial Park** 24D. LOCATION (City, town, or county) (State) **Saint Petersburg Fla.**

DATE RECEIVED BY LOCAL REGISTRAR **Oct 8 1950** REGISTRAR'S SIGNATURE **Anthony J. Williams** 25. FUNERAL DIRECTOR'S ADDRESS **Everworth Armacost 1091**

VS 150  
OCT - 9 1950  
**5118 Surgen Oak Ave**  
**5-9-50**

MEDICAL CERTIFICATION

correct use is especially important. Incomplete, please write the cause of death.

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

7709

WATER RESOURCES DIVISION  
SALT LAKE CITY, UTAH

REPORT OF THE  
SALT LAKE CITY WATER RESOURCES DIVISION

ON THE  
SALT LAKE CITY WATER RESOURCES DIVISION

FOR THE  
SALT LAKE CITY WATER RESOURCES DIVISION

BY  
SALT LAKE CITY WATER RESOURCES DIVISION

FOR THE  
SALT LAKE CITY WATER RESOURCES DIVISION

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SALT LAKE CITY WATER RESOURCES DIVISION

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Ringgold Willson*

2. DATE  
OF  
DEATH

*10/8/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

*St. Agnes Hospital*

Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*Md*

*KENT*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Be Rock Hall*

D. STREET ADDRESS (If rural, give location)

*6400*

5. SEX

*M*

6. COLOR OR RACE

*W*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

*6-11 1911*

9. AGE (in years  
last birthday)

*39*

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*SON of FARM OWNER*

10B. KIND OF BUSINESS OR INDUSTRY

*Farmer*

11. BIRTHPLACE (State or foreign country)

*Md*

12. CITIZEN OF  
WHAT COUNTRY?

*USA*

13. FATHER'S NAME

*James E.*

14. MOTHER'S MAIDEN NAME

*Mary Ringgold*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

*NO*

*NO*

16. SOCIAL  
SECURITY NO.

*NO*

17. INFORMANT

ADDRESS

*HOSPITAL RECORDS*

18. *754.4*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Congenital Heart Disease*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) *Emphysema*

(C) *C. D. Vernon Lague*

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from *10/7*, 19*50*, to *10/8*, 19*50*, that I last saw the deceased alive on *10/8*, 19*50*, and that death occurred at *7:45* m. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Oct 18 - 91950*

OCT - 91950

*10010*

*Rock Hall KENT Md*  
*Chestertown, Md. 123*

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**EDNA**

**HANSON**

2. DATE OF DEATH  
**October 8 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION **Doctor's Hospital**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland** B. COUNTY **Baltimore**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore 16-08**

D. STREET ADDRESS (If rural, give location)  
**715 Frontley St.**

Yrs.  
Mos.  
Days

Length of stay in Baltimore **10 years**

5. SEX

**Female White**

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Married**

8. DATE OF BIRTH

**Oct. 12, 1896**

9. AGE (In years last birthday)

**53**

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Housewife**

10B. KIND OF BUSINESS OR INDUSTRY

**Business**

11. BIRTHPLACE (State or foreign country)

**Maryland**

12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**Charles C. Sauter**

14. MOTHER'S MAIDEN NAME

**Ella Starn**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no or unknown) (If yes, give war or dates of service)

**No**

16. SOCIAL SECURITY NO.

**None**

17. INFORMANT

**Raymond C. Hanson**

ADDRESS

18. **443X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Cerebral Hemorrhage**

**2 weeks**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Hypertensive Cardio VASCULAR Disease**

**over 1 year**

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **July 12, 1948** to **October 8, 1950**, that I last saw the deceased alive on **Oct. 8, 1950**, and that death occurred at **7:30 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE

**Melvin N. Borden**

M. D.

23B. ADDRESS

**2030 W. Fayette St.**

23C. DATE SIGNED

**10/8/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**10/11/50**

24C. NAME OF CEMETERY OR CREMATORY

**London Park Baltimore Md.**

24D. LOCATION (City, town, or county)

**Baltimore Md.**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

**OCT - 9 1950**

REGISTRAR'S SIGNATURE

**Wilmington Williams, Md.**

25. FUNERAL DIRECTOR

**Edison Sons Catonsville**

ADDRESS

**093 d Md.**

MEDICAL CERTIFICATION

STATE OF

NEW YORK

IN SENATE

1897

1

REPORT OF THE

COMMISSIONER OF

THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

APRIL 18, 1896

ALBANY: J. B. LIPPINCOTT & CO.,

PRINTERS, 1897.

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Anna M. Brown

2. DATE  
OF  
DEATH

Oct. 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

839 S. Conkling St.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

839 S. Conkling St.

Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Nov. 23, 1871

9. AGE (in years  
last birthday)

78

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

house wife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Jacob Sauter

14. MOTHER'S MAIDEN NAME

not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

J. H. Brown 839 S. Conkling St.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

Coronary Thrombosis

4 days.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1, 1950, to Oct. 5, 1950, that I last saw the  
deceased alive on Oct. 5, 1950, and that death occurred at 5:45 Pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

10/9/50

Oak Lawn

Baltimore Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT-9 1950

VS 150

Huntington Williams, M.D.

Blair F. Hoffman 1639 Broadway

094a

MEDICAL CERTIFICATION

18-873

RECEIVED  
JAN 10 1964

100-100000

N-425-8639

50 8639

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM

NELSON

2. DATE  
OF  
DEATH

October 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Provident Hospital

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2349 Madison Avenue

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

9. AGE (in years  
last birthday)

42

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pa

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Michael Nelson

14. MOTHER'S MAIDEN NAME

Linda Webb

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Michael Nelson 1316 Lawrence St

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. ...

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

October 4, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

10-9-50

24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn

24D. LOCATION (City, town, or county)

Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

FUNERAL DIRECTOR

Geo. G. Nelson

ADDRESS

1303 Presumably

VS 151

754 6M

0932

CERTIFICATE OF DEATH

10-22-53

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of physician: _____</p>	
<p>8. Signature of registrar: _____</p>	
<p>9. Signature of informant: _____</p>	
<p>10. Date of registration: _____</p>	



A-423  
50 8640BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8640  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Bert Alston

2. DATE  
OF  
DEATH

October 7-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

5. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Baltimore City Hospitals

4940 Eastern Ave.

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

581 Baker Street

Length of stay in Baltimore

3 yrs ?

Yrs.  
Mos.  
Days

6. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

73?

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

2009 Greenberry Rd.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Baltimore City Hospitals  
Records: 4940 Eastern Ave.

18. 42010

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease

4 yrs.

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Pulmonary Edema

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-2-1947 to 10-7-1950 that I last saw the deceased alive on 10-7-1950 and that death occurred at 5:25 AM from the causes and on the date stated above.

23A. SIGNATURE

J. S. Rogers M.D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

10-7-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

10-10-50

24C. NAME OF CEMETERY OR CREMATORY

not auburn.

24D. LOCATION (City, town, or county)

not

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

19500

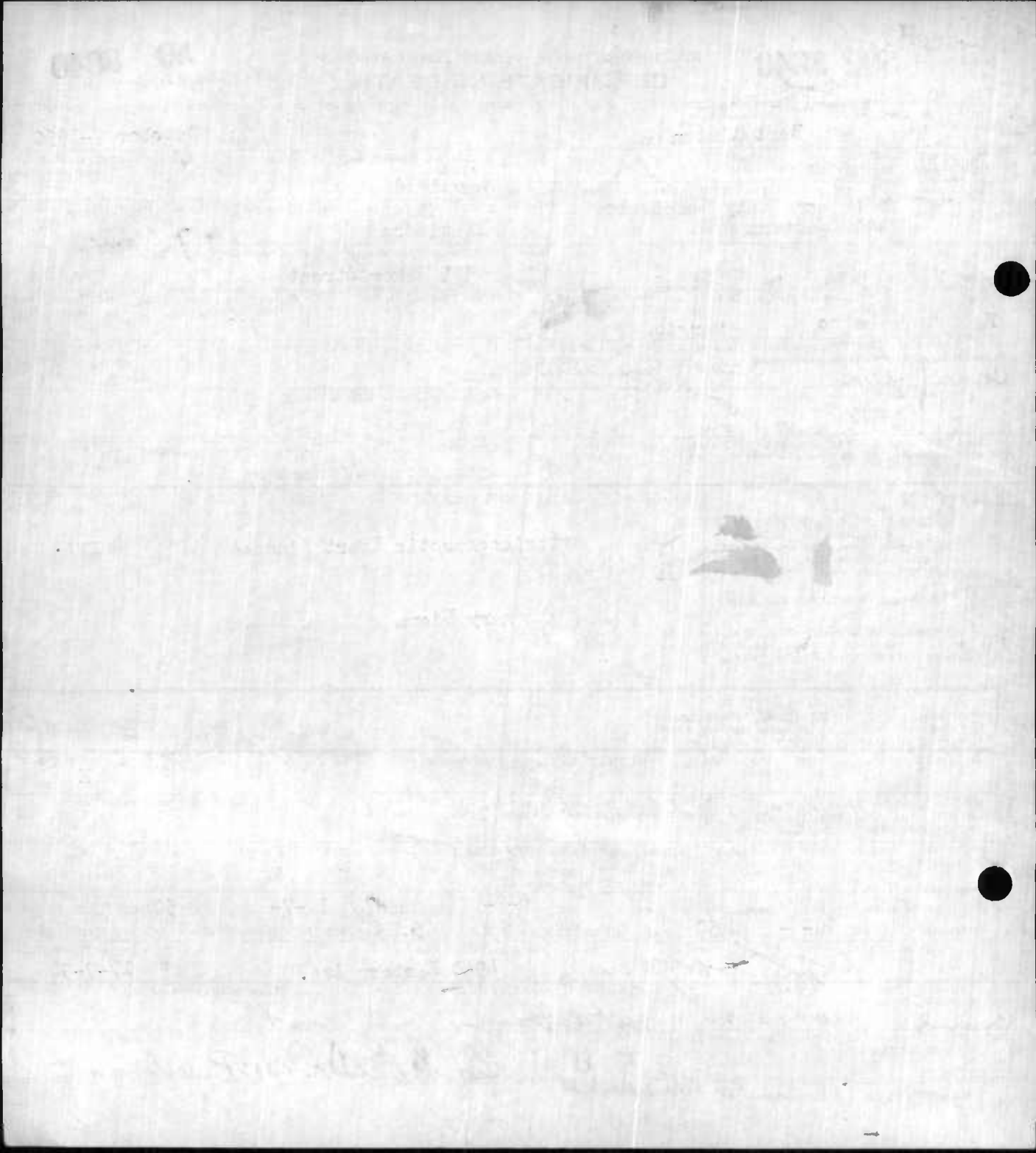
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OCT - 9 1950

Washington, D.C.

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R-500

50 8641

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8641  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GRANT FRANKLIN RENNA

2. DATE  
OF  
DEATH

10/6/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

38 University

Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 13-03

D. STREET ADDRESS (If rural, give location)

1206 W. North Ave.

5. SEX

m

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
divorced

8. DATE OF BIRTH

Oct. 1, 1900

9. AGE (in years  
last birthday)

50

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
bricklayer10B. KIND OF BUSINESS OR INDUSTRY  
construction

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Phillip U. Renna

14. MOTHER'S MAIDEN NAME

Emma Fisher

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
no16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Mae Greenwood - 1206 W. North Ave.

18. 581.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

24 hrs

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Exsanguination

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Bleeding esophageal varices  
Laennec's Cirrhosis Liver

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Prob. intracerebral hemorrhage

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10/5, 1950 to 10/6, 1950, that I last saw the deceased alive on 10/6, 1950 and that death occurred at 6:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10.10.50

24C. NAME OF CEMETERY OR CREMATORY

St. John's Cem.

24D. LOCATION (City, town, or county)

Ellicott City, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Huntington Williams

25 Mr. J. F. McKenney &amp; Sons - Balt

OCT 9 1950

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1100



R-520

50 8642

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8642

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Ellen Ryans</i>			2. DATE OF DEATH <i>Oct 7, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>824 N. Dallas St</i>			C. CITY OR TOWN <i>Baltimore</i> 7-05 D. STREET ADDRESS (If rural, give location) <i>824 N. Dallas St</i>		
Length of stay in Baltimore <i>25 yrs.</i>			Yrs. Mos. Days		
5. SEX <i>F</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Dec. 6, 1901</i>		9. AGE (In years last birthday) <i>48 49</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Midway S. C.</i>		12. CITIZEN OF WHAT COUNTRY <input checked="" type="checkbox"/>
13. FATHER'S NAME <i>James Washington</i>			14. MOTHER'S MAIDEN NAME <i>Hattie Stokes</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Annie Higgins 824 N. Dallas St</i>		

18. <i>491x</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Pneumonia</i>		CAUSE OF DEATH (A) <i>Pneumonia</i> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO	

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *9/24*, 1950, to *10/7*, 1950, that I last saw the deceased alive on *10/7*, 1950, and that death occurred at *2:15 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Ellen A. Laford</i>	23B. ADDRESS <i>822 N. Oms</i>	23C. DATE SIGNED <i>10/9/50</i>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Oct 10/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>A. A. County Md.</i>
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DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>William H. Williams</i>	25. FUNERAL DIRECTOR <i>Wm. H. Williams</i>	ADDRESS <i>1129 N. Carroll St</i>
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OCT-9-1950

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B-520  
50 8643BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8643

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Carrie A E. Banks</i>		2. DATE OF DEATH <i>10/6-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>MD</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>2611 Spellman Road</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore MD 25-32</i>	
Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>2611 Spellman Rd</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Jan. 9, 1875</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>75</i>
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Peter J. Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Annie ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Clarence Bank</i>		ADDRESS <i>2611 Spellman Rd</i>	

18. *592X*  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## CAUSE OF DEATH

(A) *Chr. nephritis +*  
DUE TO *Ure mia.*

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_  
DUE TO \_\_\_\_\_

(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *0* 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *9/24*, 19*50*, to *10/6*, 19*50*, that I last saw the deceased alive on *10/6*, 19*50*, and that death occurred at *11 A.*, from the causes and on the date stated above.

23A. SIGNATURE *B. R. Kitter* M. D. 23B. ADDRESS *2134 Wood Hill Ct* 23C. DATE SIGNED *10/6-50*24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 24B. DATE *Oct. 1950* 24C. NAME OF CEMETERY OR CREMATORY *Arbutus Mem. Park* 24D. LOCATION (City, town, or county) (State) *Arbutus Md*DATE RECEIVED BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE *Thurston Williams* 25. FUNERAL DIRECTOR *Mrs. Robert G. Elliott & Daughters* ADDRESS *1129 N. Carroll St*OCT-9-1950  
VS 150  
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RECEIVED  
JAN 20 1953

RECEIVED  
JAN 20 1953

F-422 8644

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8644

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Kenneth Fowles

2. DATE  
OF  
DEATH

Oct. 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

809 N. Dallas ST.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

809 N. Dallas ST.

Length of stay in Baltimore

10 yrs.

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

11 Under 1 Year 11 Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 401.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/15, 1949 to 10/7, 1950, that I last saw the deceased alive on 10/7, 1950, and that death occurred at 3:54 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 9 1950

1129 N. Caroline St.

58C

RECEIVED BY THE DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF ENGINEERS

General Order

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W-325  
50 8645BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 8645

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <u>Lilia Watkins</u>		2. DATE OF DEATH <u>10/7/1950</u>	
3. PLACE OF DEATH: A. <u>Baltimore City, Maryland</u> <u>Balto. City</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>606 North Dallas Street</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <u>Baltimore City</u> <u>7-05</u>	
D. STREET ADDRESS (If rural, give location) <u>606 North Dallas Street</u>		8. DATE OF BIRTH <u>7/3/1889</u> 9. AGE (In years last birthday) <u>51</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>Col.</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
13. FATHER'S NAME <u>Benjamin Owens</u>		14. MOTHER'S MAIDEN NAME <u>Annie Owens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Maggie Brown</u>		ADDRESS <u>606 N. Dallas St</u>	

18. <u>331X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <u>Cerebro-vascular Accident</u> DUE TO (B) <u>Hypertension</u> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>  <u>?</u>
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19A. DATE OF OPERATION <u>0</u>	19B. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 10/5, 1950, to 10/7, 1950 that I last saw the deceased alive on 10/5, 1950, and that death occurred at 12:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE <u>J. Preston Grant</u>	23B. ADDRESS <u>601 N. Carrollton</u>	23C. DATE SIGNED <u>10/7/50</u>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10/11/1950</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Vincent Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Chester Co. S.C.</u>
---	-----------------------------	--	---

DATE RECEIVED BY LOCAL REGISTRAR <u>OCT-9-1950</u>	REGISTRAR'S SIGNATURE <u>Eustington Williams</u>	25. FUNERAL DIRECTOR <u>Thygo, Wilson</u>	ADDRESS <u>1000 Beatty</u>
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G-125

50 8646

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8646

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Margaret Gibson</b>		2. DATE OF DEATH <b>10/3/1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto. City</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>1525 East Lombard Street</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore City 3-01</b>	
Length of stay in Baltimore <b>7 Yrs.</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1525 East Lombard Street</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>2/5/1874</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (In years last birthday) <b>76</b> If Under 1 Year Months: Days Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>London Co. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Phillipe</b>		14. MOTHER'S MAIDEN NAME <b>Isabell Lewis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Ida Phillipe</b>		ADDRESS <b>1525 E. Lombard St</b>	

18. **422.1**

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

**Cerebro-vascular disease**

DUE TO

**7.**

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **0**

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **Sept 30**, 19**50**, to **10-3-**, 19**50**, that I last saw the deceased alive on **Oct 3**, 19**50**, and that death occurred at **7 a.m.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

**Burial****10/7/1950****Mt Calvary Cem.****Brooklyn Md.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**OCT-9-1950****Esther J. Williams****Elvyn O. Wilson, 1100 Beantley Ave**

30 0000

WATLEY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10-10-19

NAME OF DECEASED

WATLEY

AGE

1/2/1902

SEX

MALE

10-10-19

DATE OF DEATH

Signature

10-10-19

10-10-19

Signature

10/10/19

Signature

Signature

K-620 50 8647

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Wilhelm Kraska</b>		2. DATE OF DEATH <b>10/6/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore - 22 Dundalk</b>	
Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>7163 Holabird Avenue 5300</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>9/6/1931</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Apprentice</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Shoe Factory</b>	9. AGE (In years last birthday) <b>19</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frederick Kraska</b>		14. MOTHER'S MAIDEN NAME <b>Olga Otto</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Frederick W. Kraska (Father)</b>		ADDRESS <b>7163 Holabird Avenue</b>	

18. <b>201X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hodgkin's Disease</b>	CAUSE OF DEATH (A) <b>Hodgkin's Disease</b> DUE TO (B) _____ DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ DUE TO (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>9/25/50</b>	19B. MAJOR FINDINGS OF OPERATION <b>Lymph gland compatible c Hodgkin's</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **9/18/50**, 19\_\_, to **10/6/50**, 19\_\_, that I last saw the deceased alive on **10/6/50**, 19\_\_, and that death occurred at **2:53P.** m., from the causes and on the date stated above.

23A. SIGNATURE <b>William B. Cooper Jr.</b>	23B. ADDRESS <b>1213 Light Street</b>	23C. DATE SIGNED <b>10/6/50</b>
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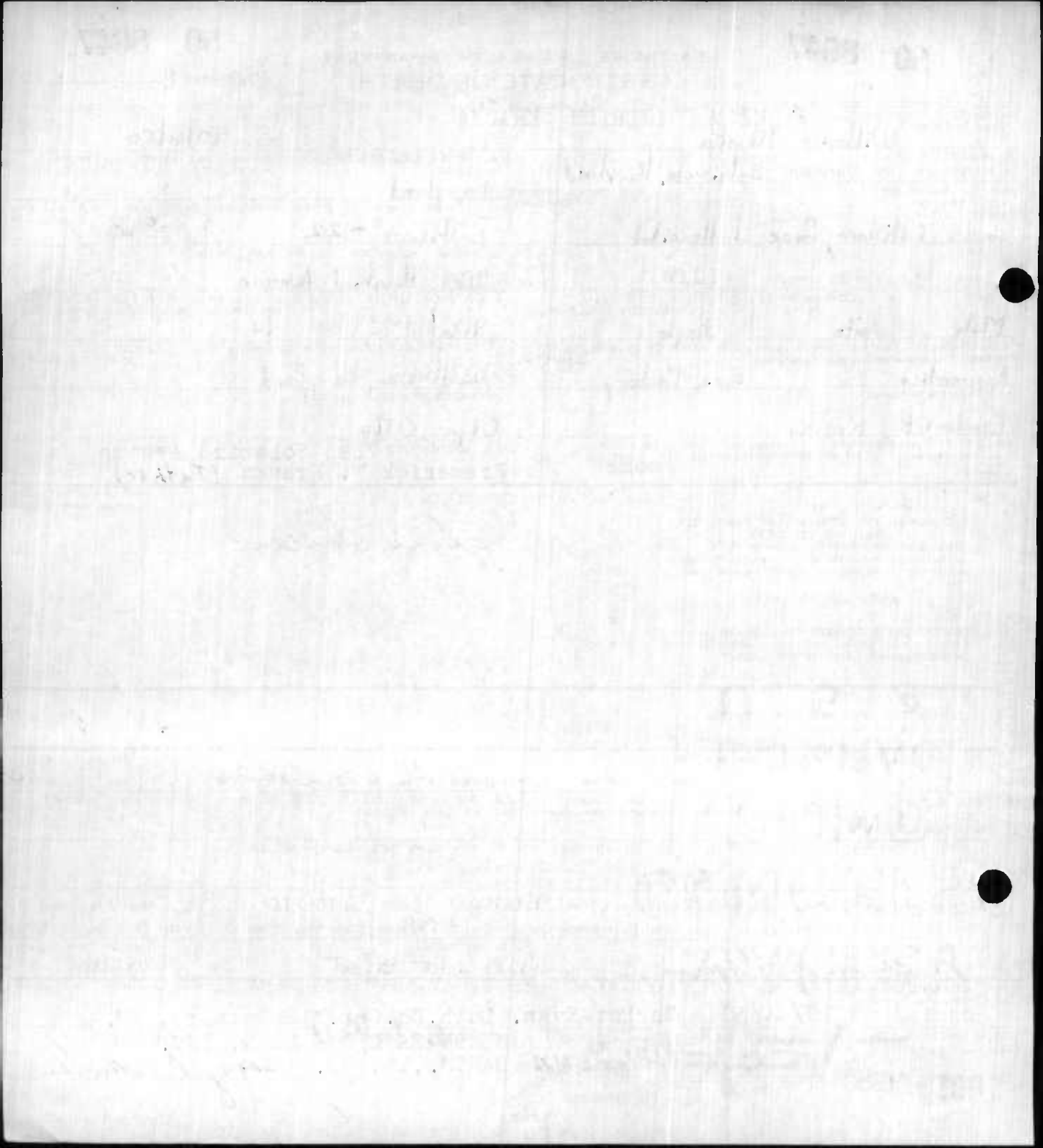
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24B. DATE <b>10/10/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Christ Evan. Luth. Ch. Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>Thurston Williams</b>	HISTORICAL REGISTRAR <b>HENRI SANDER &amp; SONS, INC.</b> ADDRESS <b>BALTO., 13, MD.</b>	

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MEDICAL CERTIFICATION



E-416  
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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Gertrude Marie Elburn</b>			2. DATE OF DEATH <b>Oct. 8, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>12-07</b>		
Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>2651 Miles Ave.</b>		
SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec. 10, 1913</b>		9. AGE (In years last birthday) <b>36</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Michael Piechnick</b>			14. MOTHER'S MAIDEN NAME <b>Dorothy Cooper</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Burton Elburn, 2651 Miles Avenue</b>		

18. <b>E 812.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Fracture of skull and both legs</b> DUE TO <b>Multiple lacerations, contusions and abrasions</b> DUE TO <b>Antecedent causes</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Other significant conditions contributing to the death, but not related to the disease or condition causing it.</b>	CAUSE OF DEATH (A) <b>Fracture of skull and both legs</b> DUE TO (B) <b>Multiple lacerations, contusions and abrasions</b> DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Huntington Ave. at 26th St.</b> <b>12/7</b>		
21D. TIME (Month) (Day) (Year) (Hour) of INJURY <b>Oct. 8, 1950 7 P m.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Pedestrian struck by automobile</b>		
22. I certify that I took charge of the remains described above, held an <b>Inspection &amp; Inq.</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .				
23A. SIGNATURE <b>Stanley H. Durlacher</b> M.D.		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>Oct. 9, 1950</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24B. DATE <b>10/11/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>9/1950</b>	REGISTRAR'S SIGNATURE <b>Wm. Earl, Inc.</b>	25. FUNERAL DIRECTOR ADDRESS <b>1217 St. Paul Street</b>	

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STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

30 018

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1910		New York City	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
Jan 15, 1955		10:30 AM		Home		Dr. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**JOSEPH A. BROWN**

2. DATE  
OF  
DEATH

**October 6, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

**Maryland**

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

**Union Memorial Hospital**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore**

D. STREET ADDRESS (If rural, give location)

**3219 N. Calvert Street**

Yrs.  
Mos.  
Days

Length of stay in Baltimore

SEX

**male**

6. COLOR OR RACE

**white**

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

**widowed**

8. DATE OF BIRTH

**about 1874**

9. AGE (In years  
last birthday)

**76**

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

**retired**

10B. KIND OF BUSINESS OR  
INDUSTRY

**plumber**

11. BIRTHPLACE (State or foreign country)

**Maryland**

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

**John Brown**

14. MOTHER'S MAIDEN NAME

**Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

**no**

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

**Joe E. Brown 520 Arlington Avenue**

18. **E890.0**

**CAUSE OF DEATH**

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) **Carbon monoxide poisoning**

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

**home**

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

**3219 N. Calvert Street**

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

**October 6, 1950 ?**

m.

21E. INJURY OCCURRED  
WHILE AT NOT WHILE  
WORK ☐ AT WORK ☒

21F. HOW DID INJURY OCCUR?

**Inhaled fumes from coal furnace**

22. I certify that I took charge of the remains described above, held an **Inquiry & Inspection** thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

**William H. Smith**

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

**Oct. 7, 1950**

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

**burial**

24B. DATE

**10/10/50**

24C. NAME OF CEMETERY OR CREMATORY

**Moreland Park**

24D. LOCATION (City, town, or county)

**Baltimore,**

**Maryland**

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**William H. Smith**

25. FUNERAL DIRECTOR

**H. M. Cook, Inc.**

ADDRESS

**1217 St. Paul Street**

1940 (2)

CALIFORNIA CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

1940 (2)

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## CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

P-450

50 8650

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Patrick Joseph Phelan

2. DATE  
OF  
DEATH

October 6, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's Hospital

Length of stay in Baltimore

65 yr.

Yrs.  
Mos.  
Days

SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR  
INDUSTRY

Balto. Transit Co.

13. FATHER'S NAME

Michael Phelan

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

104 N. Milton Avenue

8. DATE OF BIRTH

Mar. 17, 1884

9. AGE (In years  
last birthday)

86

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Mary Duggan

17. INFORMANT

ADDRESS

Helen Phelan

104 N. Milton Ave.

18. E903.0, 450.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Renal failure with acidosis

2 da.

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Generalized visceral failure C. J. LUBINSKI, M.D.

DUE TO

Per: Stanley H. Dember M.D.

CHIEF OR ASST. MEDICAL EXAMINER

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Generalized arteriosclerosis

Fracture, left femur

16 da.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

Accident

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

At Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

104 N. Milton Avenue

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

about Aut. 21, 1950

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Tripped on a chair and fell.

22. I hereby certify that I attended the deceased from 8/30/, 1950, to 10/6/, 1950 that I last saw the  
deceased alive on 10/6/, 1950, and that death occurred at 2:15 PM., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

1400 N. Caroline Street

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

10/10/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

3000 E. Baltimore St.

1944

S-436

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8651

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

50

8651

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Arnes Loretta Slattery

2. DATE  
OF  
DEATH

October 8, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

423 N. Luzerne Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

423 N. Luzerne Ave.

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Florance Slattery

14. MOTHER'S MAIDEN NAME

Anna Scanlan

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL  
SECURITY NO.

-----

17. INFORMANT

ADDRESS

Eugene V. Slattery 3004 Rueckert Ave

18. 442x

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

myocardial failure - chr. myocard Sept 23/50

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Cardio-Vascular Renal Disease -  
chr. hypotension -  
arterio-sclerosis

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., In or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from Sept 23, 1950, to Oct 8, 1950, that I last saw the  
deceased alive on Oct 3, 1950, and that death occurred at 8:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

10/11/50

New Cathedral Cem.

Baltimore Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

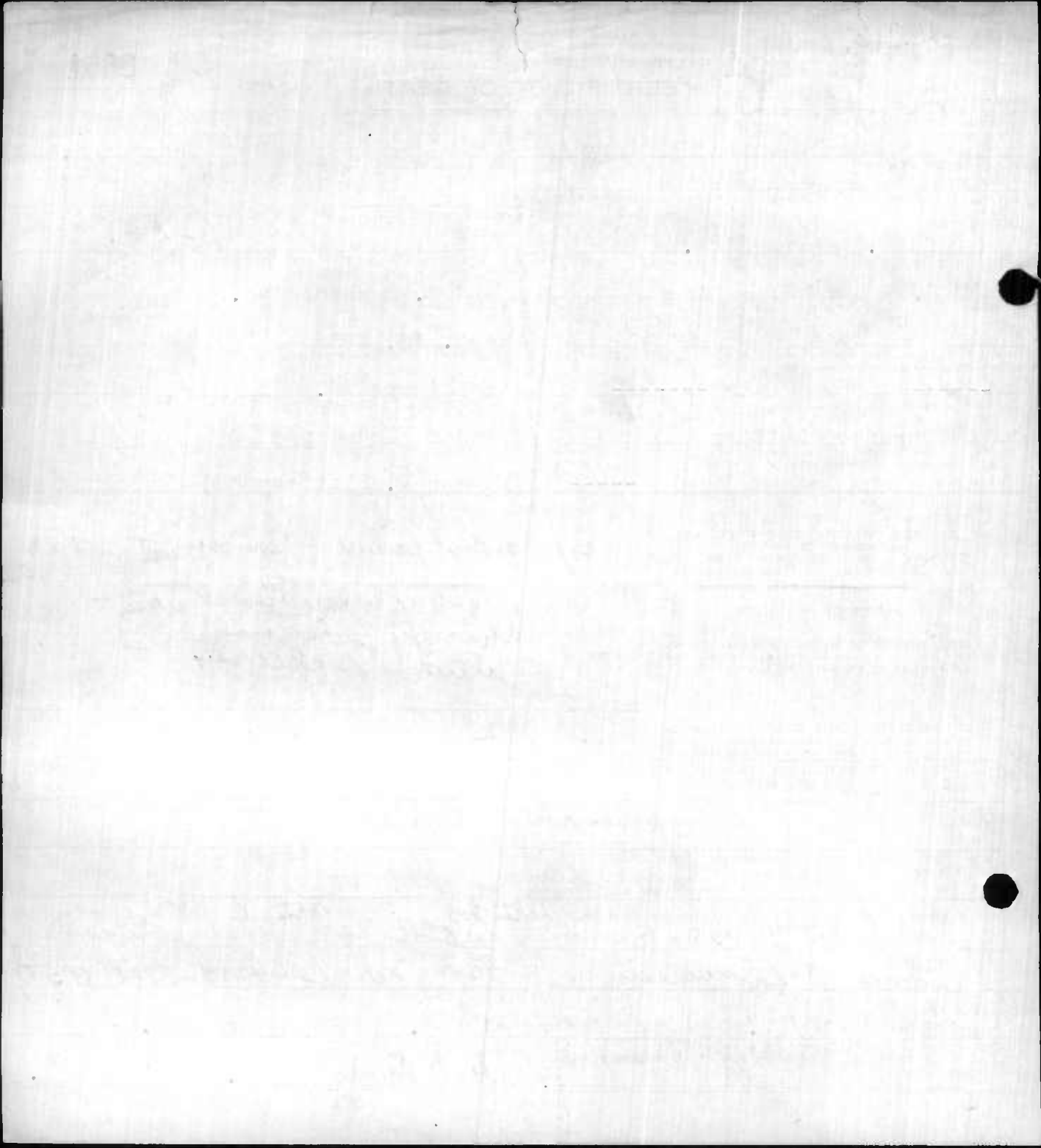
25. FUNERAL DIRECTOR

ADDRESS

OCT-9-1950

John D. Moran

3000 E. Baltimore St.





K-325  
10 136638

50 8652

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8652  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Asa Kitzmiller

2. DATE OF DEATH  
Oct. 8, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE Baltimore City Hospitals

4940 Eastern Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 6-03D. STREET ADDRESS (If rural, give location)  
2120 E. Baltimore St.

Length of stay in Baltimore

4 Years Mos. Days

5. SEX  
Male6. COLOR OR RACE  
White7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Divorced

8. DATE OF BIRTH

Aug. 15, 1900

9. AGE (In years last birthday)  
5010. Under 1 Year Months: Days  
10 7

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Turner

10B. KIND OF BUSINESS OR INDUSTRY

Saw mill

13. FATHER'S NAME

John Kitzmiller

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

14. MOTHER'S MAIDEN NAME

Civilla Dodde

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)

(Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Baltimore City Hospitals  
Records- 4940 Eastern Avenue

18. 364x

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Infectious Polyneuritis

DUE TO

11 mos.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 17, 1950, to Oct. 8, 1950, that I last saw the deceased alive on Oct. 8, 1950, and that death occurred at 9:30 PM, from the causes and on the date stated above.

23A. SIGNATURE

W. Crozer

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

10-9-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT-9-1950

VS 150

950 31

0876

3028 02

UNITED STATES DEPARTMENT OF THE ARMY  
HEADQUARTERS, ARMY  
WASHINGTON, D. C. 20315

3028 02

MEMORANDUM FOR THE RECORD

MEMORANDUM FOR THE RECORD

MEMORANDUM FOR THE RECORD

MEMORANDUM FOR THE RECORD

AB-133529

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8653  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William Wroten

2. DATE  
OF  
DEATH

10-7-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTIONBaltimore City Hospitals  
4940 Eastern Ave.4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Baltimore City Hospitals (Homeless)

Yrs.  
Mos.  
Days

Length of stay in Baltimore

Life

SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Sept- 27- 1899

9. AGE (In years  
last birthday)

51

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR  
INDUSTRY

ODD JOBS

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Wroten

14. MOTHER'S MAIDEN NAME

Linda Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT Baltimore City Hospitals  
Records: 4940 Eastern Ave.

18. 527.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary Emphysema

DUE TO

20yrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐I hereby certify that I attended the deceased from 11-17-1949, to 10-7-1950 that I last saw the  
deceased alive on 10-7-1950. and that death occurred at 4:15A.M., from the causes and on the date stated above.

23A. SIGNATURE

P. S. Rogers

M. D.

23B. ADDRESS

Baltimore City Hospitals  
4940 Eastern Ave.

23C. DATE SIGNED

10-8-1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

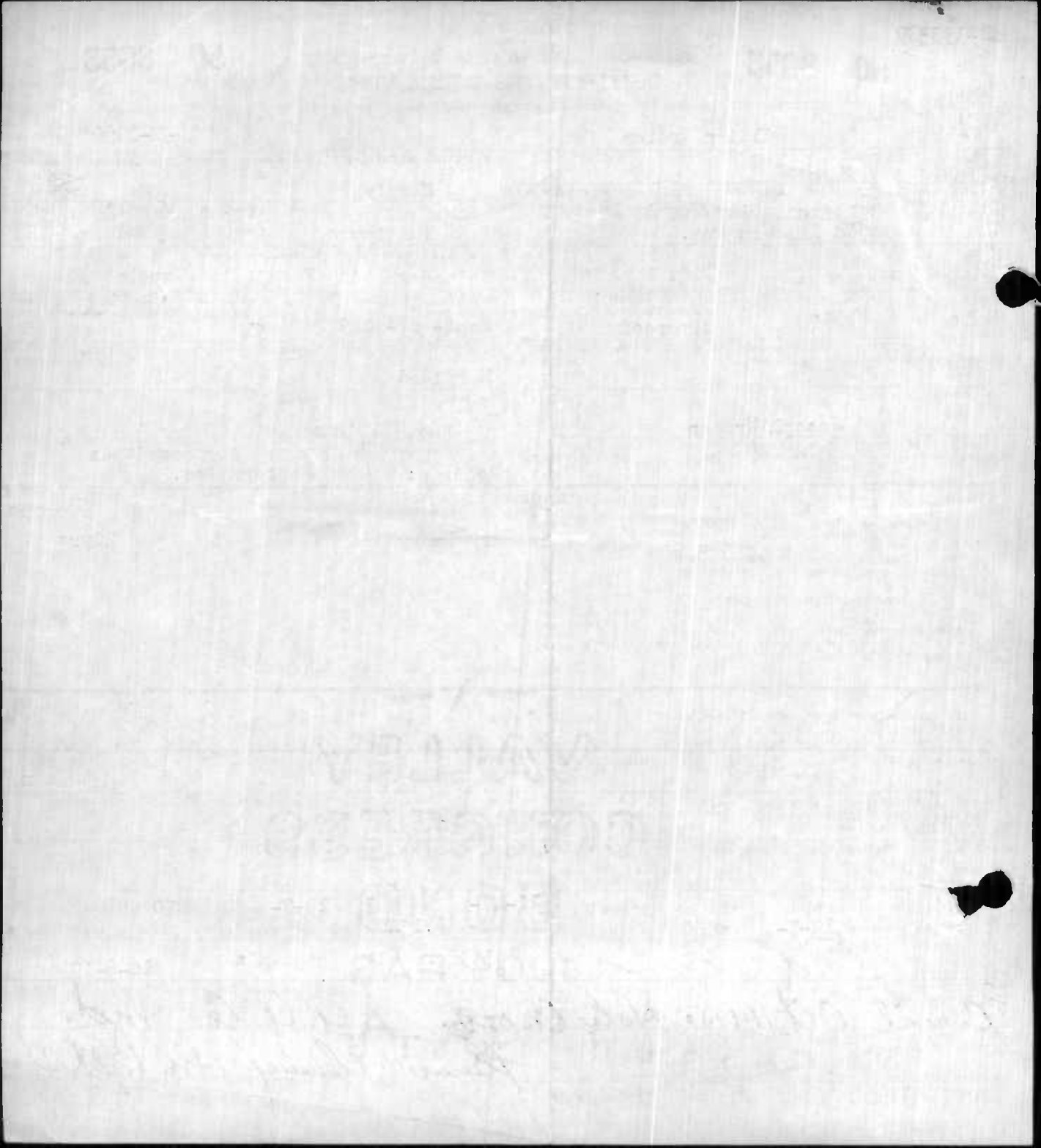
ADDRESS

OCT 12 1950

97099

113.0

MEDICAL CERTIFICATION



632 CERTIFICATE CORRECTED 10-13-50

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Anne F. Curtis,

2. DATE  
OF  
DEATH

Oct. 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

4640 Pimlico Road.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore,

D. STREET ADDRESS (If rural, give location)

4640 Pimlico Road.

Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

13. FATHER'S NAME

Henry Curtis McComas

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. Margaret Tully, 4640 Pimlico Road.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

Coronary Thrombosis

2 1/2 hrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Cardio-Vascular Disease

2 years

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

4 1/2 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT

NOT WHILE

WORK ☐AT WORK ☐22. I hereby certify that I attended the deceased from 4/28, 1946 to 10/7/50, that I last saw the  
deceased alive on 10/7, 1950, and that death occurred at 11:40 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. O.

3432 Frederick Ave.,

10/ /50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

Oct. 11, 1950

24C. NAME OF CEMETERY OR CREMATORY

Cathedral Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

R. H. Williams, M.D.

B. Vernon

4611 Park Heights Ave.,

OCT 9 1950

061.0

MEDICAL CERTIFICATION

APR 03

1951



ES-137753

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Edward George Riemers OR REIMERS

2. DATE  
OF  
DEATH

10-7-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

5. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1242 S. Ellwood Avenue (24)

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec. 26, 1900

9. AGE (in years  
last birthday)

49

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LEADER LOFTSMAN

10B. KIND OF BUSINESS OR INDUSTRY

U.S. COAST GUARD

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Riemers (D)

14. MOTHER'S MAIDEN NAME

Joanna ? (D) LONNE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS 4940

Records\* Balto. City Hospitals Eastern Ave

18. 002X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis

DUE TO

7 Mos.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

9-24-50

19B. MAJOR FINDINGS OF OPERATION

RUL Cavitary Tuberculosis

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-3, 1950, to 10-7, 1950, that I last saw the deceased alive on 10-7, 1950, and that death occurred at 7:35 p.m. from the causes and on the date stated above.

23A. SIGNATURE

P. S. Rogers

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

10-7-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

OCT 11 1950

24C. NAME OF CEMETERY OR CREMATORY

OAK LAWN CEMETERY

24D. LOCATION (City, town, or county)

EASTERN AVE RD

(State)

MD.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Cappel Bldg. 1800 E Lombard St.

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

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THE UNIVERSITY OF CHICAGO

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 8656

BIRTH NO. <u>43</u>		NAME OF DECEASED (Type or Print) <u>(ADDIE) ANNIE</u>		HUSBAND <u>HAMLET</u>		2. DATE OF DEATH <u>October 8, 1950</u>	
3. PLACE OF DEATH: A. <u>Baltimore City, Maryland</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>Johns Hopkins Hospital</u>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>5-02</u>			
Length of stay in Baltimore <u>1942</u> Yrs. Mos. Days				D. STREET ADDRESS (If rural, give location) <u>643 Sterling Street</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>?? 1924</u>		9. AGE (In years last birthday) <u>26</u>	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Store</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Sam Hamlet</u>				14. MOTHER'S MAIDEN NAME <u>Frances Hamlet</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-80-2094</u>		17. INFORMANT <u>Frances Hancock - Sterling St.</u>		ADDRESS <u>443</u>	
18. <u>002X</u> CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Far advanced pulmonary tuberculosis</u>							
DUE TO (A) _____							
ANTECEDENT CAUSES (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an <u>Inspection &amp; Inquiry</u> thereon and from <u>Autopsy, Inspection or Inquiry</u> the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
23A. SIGNATURE <u>William V. ...</u>				23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED <u>October 9, 1950</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>10-10-50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lynchburg Va.</u>		24D. LOCATION (City, town, or county) (State) <u>013 b</u>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. ...</u>		25. FUNERAL DIRECTOR <u>W. ...</u>		ADDRESS <u>918 - ...</u>	
US, 1st 91950 <u>7316C</u> <u>Shirley Hill ave.</u>							

MEDICAL CERTIFICATION

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH



*[The following text is mirrored bleed-through from the reverse side of the page and is not legible.]*

NAME OF DECEASED  
AGE  
SEX  
RACE  
DATE OF BIRTH  
PLACE OF BIRTH  
OCCUPATION  
CAUSE OF DEATH  
DATE OF DEATH  
PLACE OF DEATH  
SIGNATURE OF PHYSICIAN  
SIGNATURE OF REGISTRAR  
DATE OF REGISTRATION

HARTLAUB  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X 50 8657  
Registered No.

1. NAME OF DECEASED (Type or Print) <u>Linda Sue Hartlaub</u>		2. DATE OF DEATH <u>10-9-50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>University Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Pennsylvania</u> B. COUNTY <u>York</u>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>University Hospital</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Hanover</u>	
Length of stay in Baltimore <u>6</u> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <u>319 South St.</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>S</u>	8. DATE OF BIRTH <u>11-20-43</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
13. FATHER'S NAME <u>Paul Hartlaub</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>unw. hospital</u>		ADDRESS	

18. <u>204.4</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Leukemic leukemia</u> DUE TO (A) ..... ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) ..... (C) .....	INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <u>10-3</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10-3</u> , 19 <u>50</u> to <u>10-9</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>10-9</u> , 19 <u>50</u> , and that death occurred at <u>9<sup>00</sup></u> A. m., from the causes and on the date stated above.					
23A. SIGNATURE <u>Robert W. Boy</u>		23B. ADDRESS <u>University Hospital</u>		23C. DATE SIGNED <u>10-9-50</u>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Oct 11/1950</u>		24B. DATE <u>Oct 11/1950</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>	
24D. LOCATION (City, town, or county) (State) <u>Hanover York County Pa</u>		DATE RECEIVED BY LOCAL REGISTRAR <u>Oct 9 1950</u>		REGISTRAR'S SIGNATURE <u>Christington Williams</u>	
25. FUNERAL DIRECTOR <u>W. E. Feiser</u>		ADDRESS <u>Hanover Pa</u>			

0746





452  
LC 101870BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8658  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Harry Schilling

2. DATE  
OF  
DEATH

Oct. 9, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street address or location)  
Baltimore City Hospitals  
4940 Eastern Avenue4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
MarylandC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BaltimoreD. STREET ADDRESS (If rural, give location)  
No Home

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Separated

8. DATE OF BIRTH

Nov. 21, 1890

9. AGE (In years,  
last birthday)

59

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.12. CITIZEN OF  
WHAT COUNTRY?10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Taphy carrier at city hospital

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Howard Schilling (D)

14. MOTHER'S MAIDEN NAME

Mary Henry (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.17. INFORMANT  
ADDRESS  
Records- Baltimore City Hospitals  
4940 Eastern Ave.

18. 153X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Sigmoid

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Carcinomatosis

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

6-24-50

19B. MAJOR FINDINGS OF OPERATION

Incarcerated hernia discovered to be a perforating  
carcinoma of sigmoid colon

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 7, 1946, to Oct. 9, 1950 that I last saw the  
deceased alive on Oct. 9, 1950, and that death occurred at 3:45 AM., from the causes and on the date stated above.

23A. SIGNATURE

H. S. Sogren

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

10-9-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct 11 1950

24C. NAME OF CEMETERY OR CREMATORY

Dry Branch

24D. LOCATION (City, town, or county)

White Hall RD Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Kurtz Garrettsville

VS 150

4604M

0462 md

MEDICAL CERTIFICATION

Correct age is especially important in infanticide cases

50-101

STATE OF TEXAS  
COUNTY OF DALLAS

1913

1913

312 50 8659

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8659

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY C. BIEDEBACH

2. DATE  
OF  
DEATH

10-7-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

106 W. HEATH ST

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

MO

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 23-03

D. STREET ADDRESS (If rural, give location)

106 W. HEATH ST.

Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

OCT 18, 1879

9. AGE (in years  
last birthday)

20

11 Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

WEST VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

POBRY

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

WILLIAM H. BIEDEBACH 106 W HEATH ST.

18.

151X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Carcinoma of stomach,  
DUE TO (inoperable.)

?

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO \_\_\_\_\_  
(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 9, 1950 to Oct. 7, 1950, that I last saw the  
deceased alive on Oct. 7th, and that death occurred at 3 P. m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

1226 Hanover St.

23C. DATE SIGNED

10/9/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

10/10/50

24C. NAME OF CEMETERY OR CREMATORY

CEDAR HILL

24D. LOCATION (City, town, or county)

PITCHIE HIGHWAY

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

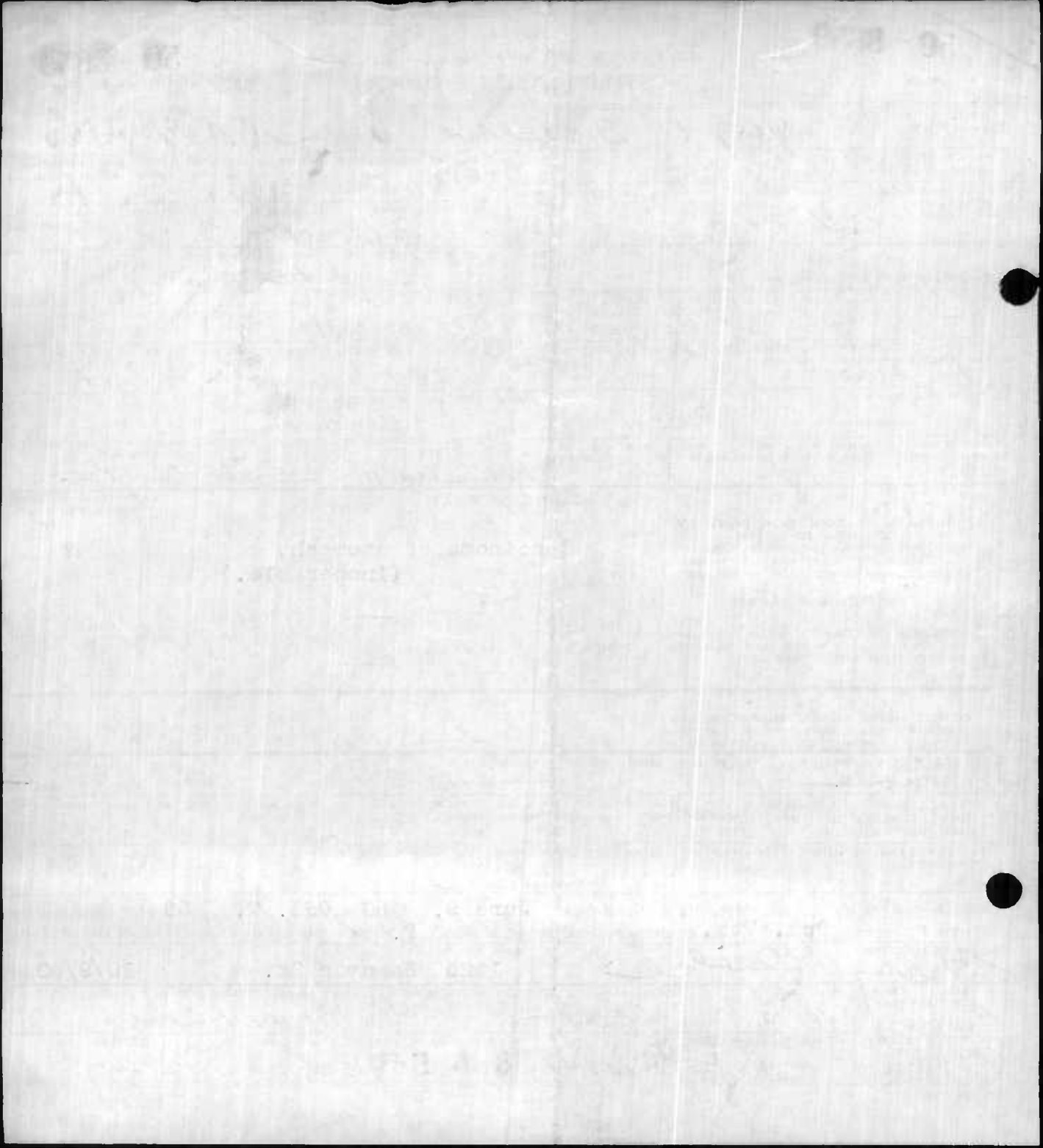
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

8 J. H. F. DENNY, Inc 715 LIGAT ST. 30



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **8660**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

**JOSEPH John**

**KUCZBORSKI**

2. DATE  
OF  
DEATH

**October 9, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**Johns Hopkins Hospital**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore 31 2-03**

D. STREET ADDRESS (If rural, give location)

**619 Bond Street, South**

5. Length of stay in Baltimore

**46 years**

6. SEX

**Male**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Married**

8. DATE OF BIRTH

**1894 ?**

9. AGE (In years last birthday)

**56**

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Iron Pitted Moulder**

10B. KIND OF BUSINESS OR INDUSTRY

**Harry C. Weiskettle Co., Inc.**

11. BIRTHPLACE (State or foreign country)

**Poland**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Joseph Kuczorski**

14. MOTHER'S MAIDEN NAME

**Rozalia ??**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

**214-03-3174**

17. INFORMANT

ADDRESS

**Mrs. Bertha Kuczorski 619 S. Bond Street**

1B. **E902-6 - E900-6**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

**Fracture of skull**

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

**Epidural hemorrhage**

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIB-UTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

**Polish National Alliance**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

**1708 Fleet Street**

21D. TIME (Month) (Day) (Year) (Hour)

**October 8, 1950 10 P. m.**

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

**Fell down stairs**

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....

23C. DATE SIGNED

ASSISTANT MEDICAL EXAMINER.....

**10-9-50**

24A. BURIAL, CREMA-TION, REMOVAL (Specify)

**Burial**

24B. DATE

**Oct 12, 1950**

24C. NAME OF CEMETERY

**St. Stanislaus**

24D. LOCATION (City, town, or county)

**Baltimore, Md.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FORMAL DIRECTOR

ADDRESS

**OCT 10 1950**

**Wilmington, Delaware**

**George A. Weber 7052 Amy St.**

V S 151

**N 803-2**

**561 3M**

**186a**

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Frances King</b>		2. DATE OF DEATH <b>10-7-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>2103 Cold Spring Lane</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Bar W. Convalescent Home</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 15-01</b>	
D. STREET ADDRESS (If rural, give location) <b>1342 Pressman St</b>			
Length of stay in Baltimore <b>1</b> Yrs. <input type="checkbox"/> Mos. <input type="checkbox"/> Days <input type="checkbox"/>		8. DATE OF BIRTH <b>?</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>ed</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>D</b>	9. AGE (In years last birthday) <b>69</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H-W.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Towson Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Buchanan</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>S. Hayes Buchanan</b>		ADDRESS <b>1342 Pressman</b>	

18. **442x** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Cardio Vascular Renal**

DUE TO

(B)

DUE TO

(C)

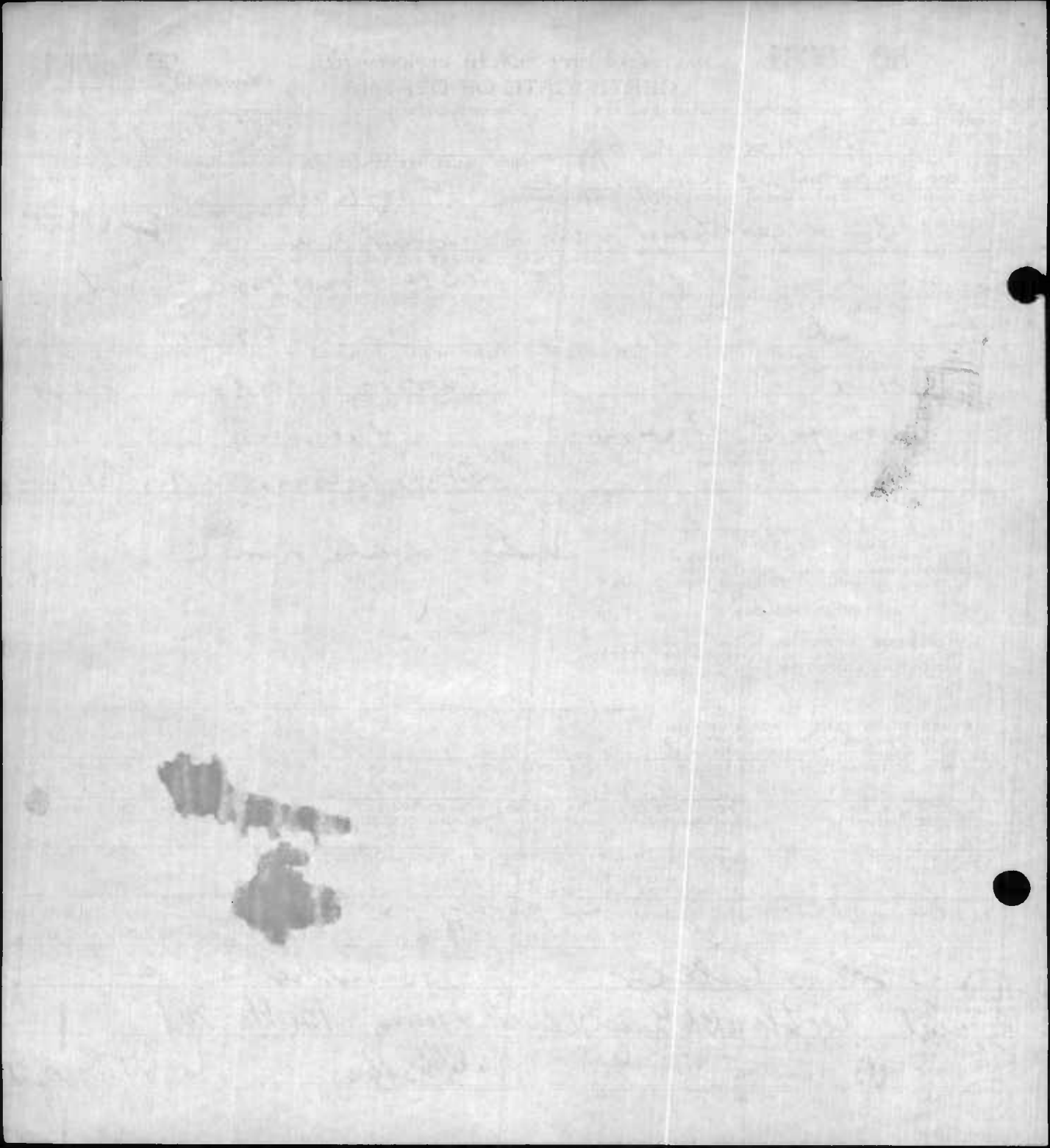
ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>9-28</b> , 19 <b>50</b> , to <b>10-5-50</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>10-5-50</b> , 19 <b>50</b> , and that death occurred at <b>7 A</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>W.B. Butler</b>		23B. ADDRESS <b>2037 Sun Drive</b>		23C. DATE SIGNED <b>10-10-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>October 10/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		25. FUNERAL DIRECTOR <b>W.E. Crooke</b>		ADDRESS <b>1463 N. Carey St</b>	



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Arthur P. Ripley

2. DATE  
OF  
DEATH

Oct. 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN

Towson

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

6 Edgecliff Road

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 22, 1905

9. AGE (In years  
last birthday)

45

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Asst. Plant Mgr.

10B. KIND OF BUSINESS OR  
INDUSTRY

Fisher Body Plant

11. BIRTHPLACE (State or foreign country)

Mass.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Leberton Ripley

14. MOTHER'S MAIDEN NAME

Mary C. Stacks

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

(If yes, give war or dates of service)

None

16. SOCIAL  
SECURITY NO.

373-10-6539

17. INFORMANT

ADDRESS

Mrs. Gladys M. Ripley, Towson, Md.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Generalized Arteriosclerosis

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an \_\_\_\_\_ thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. Smith

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Oct 8 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 11, 1950

24C. NAME OF CEMETERY OR CREMATORY

Sunset Hill Cemetery

24D. LOCATION (City, town, or county)

Flint, Michigan

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Timothy J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John Burns' Sons, Towson, Maryland

NOV 19 1944

RECEIVED  
FBI - NEW YORK

RECEIVED  
FBI - NEW YORK

NOV 19 1944

RECEIVED  
FBI - NEW YORK

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 8663

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES H. ARMENTROUT</b>			2. DATE OF DEATH <b>October 6, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 13-08</b>		
E. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>1518 Cox Street</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>divorced</b>	8. DATE OF BIRTH <b>Jan. 8, 1893</b>		9. AGE (In years last birthday) <b>57</b> If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>?</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>✓</b>
13. FATHER'S NAME <b>?</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>1st W.W. 217-07-7742</b>	17. INFORMANT ADDRESS <b>Lucille Claggett 713 W. 36th Street</b>		

18. <b>490x</b> <b>CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Lobar pneumonia</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH
--	----------------------------------

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>William W. Chenowith</i>	23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/>	23C. DATE SIGNED <b>Oct. 7, 1950</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24B. DATE <b>10-10-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	24D. LOCATION (City, town, or county) (State) <b>Frederick Avenue</b>
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DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 10 1950</b>	REGISTRAR'S SIGNATURE <i>Paul E. Chenowith, Jr.</i>	25. FUNERAL DIRECTOR ADDRESS <b>Paul E. Chenowith, Jr. 3615-17 Chestnut Ave.</b>
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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

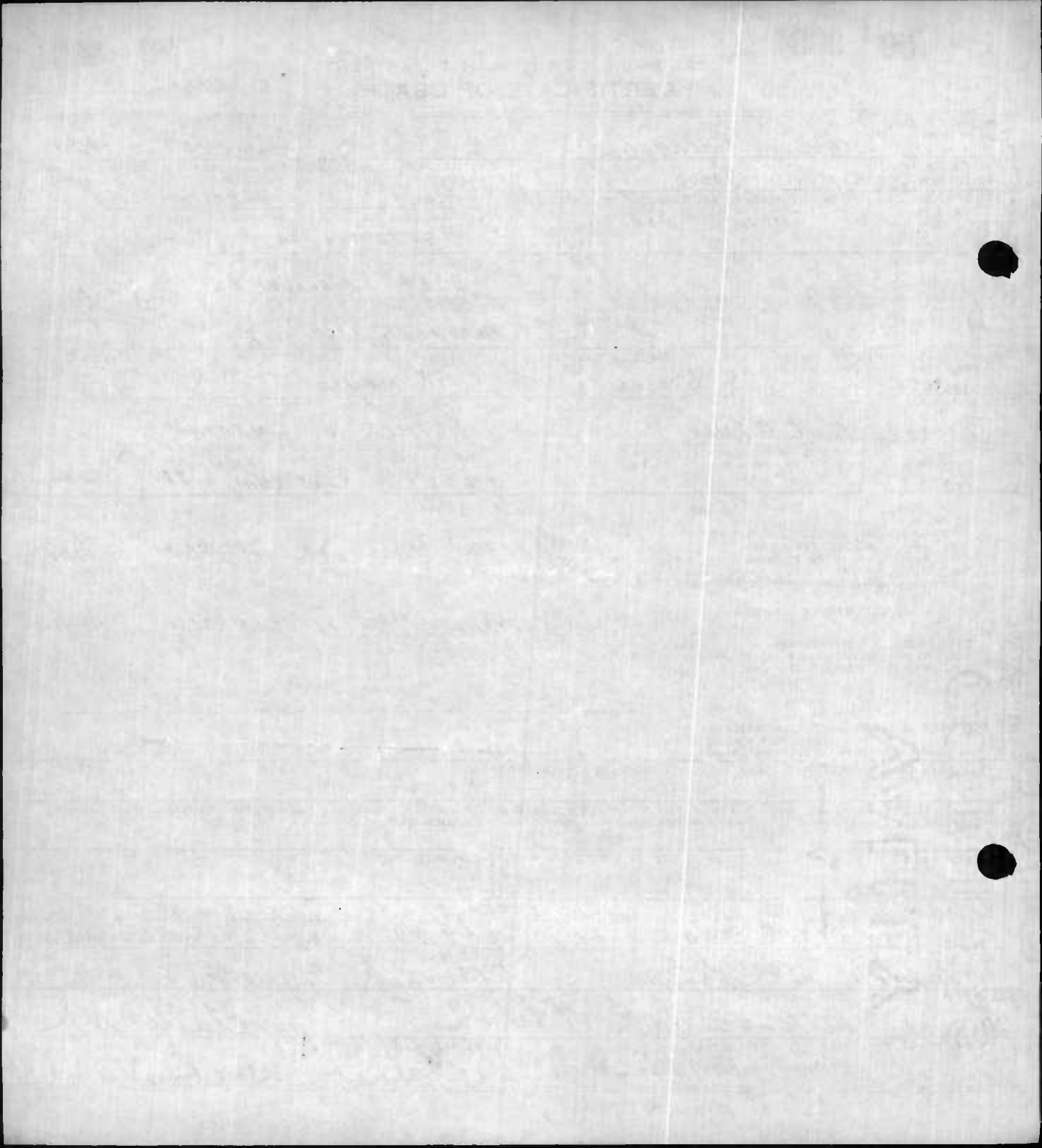
1. NAME OF DECEASED (Type or Print) <b>ISAAC CHERNAK</b>		2. DATE OF DEATH <b>OCT. 9, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>BALTO.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>3704 FAIRVIEW AVE.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE, MD. 15-38</b>	
c. Length of stay in Baltimore <b>45</b> Yrs. <b>4</b> Mos. <b>5</b> Days		D. STREET ADDRESS (If rural, give location) <b>3704 FAIRVIEW AVE.</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>W</b>	8. DATE OF BIRTH <b>MARCH 15, 1869</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GROCCER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>GROCERIES</b>	9. AGE (In years last birthday) <b>81</b>
11. BIRTHPLACE (State or foreign country) <b>RUMANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THEODORE N. CHERNAK</b>		14. MOTHER'S MAIDEN NAME <b>ESTHER V. CHERNAK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT (Son) <b>SIDNEY CHERNAK</b>		ADDRESS <b>415 GRANADA AVE.</b>	

18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>CEREBRO-VASCULAR ACCIDENT</b> DUE TO <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (C) _____	CAUSE OF DEATH  INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>  <b>—</b>
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from **SEPT. 27, 1950** to **OCT. 9, 1950** that I last saw the deceased alive on **OCT. 8, 1950** and that death occurred at **9:30 AM.**, from the causes and on the date stated above.

23A. SIGNATURE <b>Marvin Goldstein</b>		23B. ADDRESS <b>5334 Liberty Heights Rd. Balt. Md.</b>		23C. DATE SIGNED <b>OCT. 9, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-10-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Beth T. Telok</b>	
24D. LOCATION (City, town, or county) (State) <b>Balt. Md.</b>		25. FUNERAL DIRECTOR <b>Jack Kewin</b>		ADDRESS <b>2100 Eutaw Pl.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 11 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Hall</b>		26. ADDRESS _____	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**DUNNICK, DR. J. NELSON**

2. DATE  
OF  
DEATH

**Oct 9, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland **Mbg 3.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **PENN.** B. COUNTY **V-35**

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

**JOHNS HOPKINS HOSPITAL**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**YORK**

D. STREET ADDRESS (If rural, give location)  
**R. D. 5**

C. Length of stay in Baltimore

5. SEX

**MALE**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**MARRIED**

8. DATE OF BIRTH

**7-6-72**

9. AGE (in years last birthday)

**78**

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

**Physician**

11. BIRTHPLACE (State or foreign country)

**PENN.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Charles M. Dunnick**

14. MOTHER'S MAIDEN NAME

**Elizabeth Leib**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

**JOHNS HOPKINS HOSPITAL**

ADDRESS

**CAUSE OF DEATH**

18. **443x**

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

**Cerebral Hemorrhage**

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

**7 days**

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

**Hypertensive Cardiovascular disease**

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

**Old myocardial**

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., io or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **10-8** 19**50**, to **10-9**, 19**50**, that I last saw the deceased alive on **10-9**, 19**50**, and that death occurred at **530 P. M.** from the causes and on the date stated above.

23A. SIGNATURE

**Rosa M. Lane**

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**10/12/50**

24C. NAME OF CEMETERY OR CREMATORY

**Stewartstown Cemetery**

24D. LOCATION (City, town, or county)

**Stewartstown Pa**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

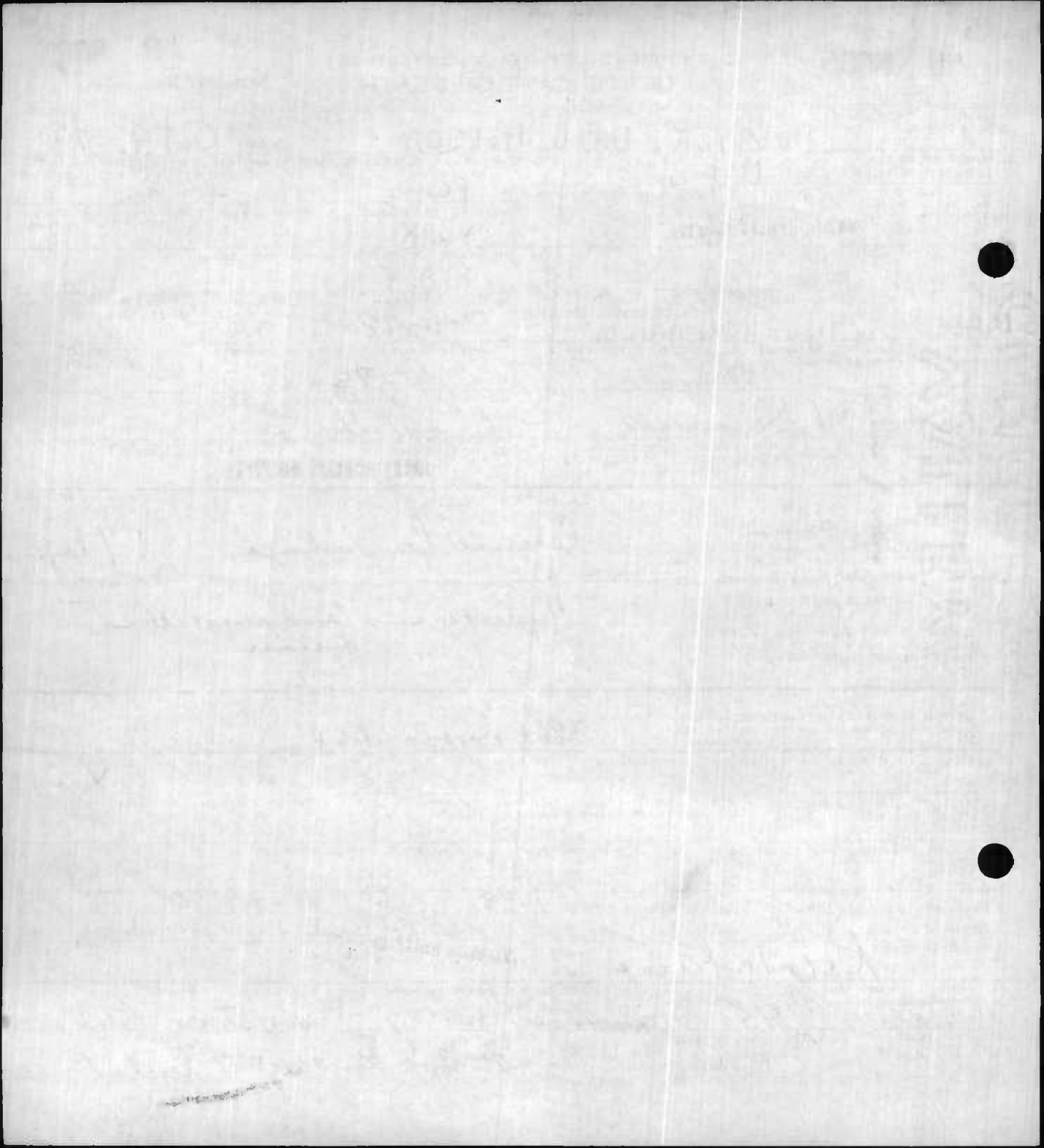
**Huntington Williams, M.D.**

25. FUNERAL DIRECTOR

ADDRESS

**Don Cook Inc. 1217 St Paul St.**

**OCT 10 1950**



- 221  
50 8666BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Joseph (K) Kiewicz / KOZAKIEWICZ

2. DATE  
OF  
DEATHOctober 9  
1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Pinecrest Sanatorium

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

Howard

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Elkridge

D. STREET ADDRESS (If rural, give location)

6623 Old Washington Road

6300

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
single

8. DATE OF BIRTH

Oct. 24, 1876

9. AGE (In years  
last birthday)

73

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

ODD JOBS

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Benjamin Lenczycki, 6623 Old Washington Rd

18. 304X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Senility with  
DUE TO Senile dementia

?

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 27, 1950, to October 9, 1950, that I last saw the  
deceased alive on October 27, 1950, and that death occurred at 6:10 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Melvin W. Bruden M. D.

23B. ADDRESS

2030 W Fayette St

23C. DATE SIGNED

10/9/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

10/10/50

24C. NAME OF CEMETERY OR CREMATORY

St. Peters

24D. LOCATION (City, town, or county) (State)

Baltimore,

Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

St. M. Cook, Inc.

ADDRESS

1217 St. Paul Street

VS 150

97099

162a

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
OFFICE OF THE REGISTRAR  
CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH	
5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. PLACE OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF FUNERAL HOME	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JUDGE		16. SIGNATURE OF CLERK	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN		19. SIGNATURE OF SURVIVOR		20. SIGNATURE OF OTHER	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Pierre O'Hare*

2. DATE  
OF  
DEATH

*Oct. 8, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

*JOHNS HOPKINS HOSPITAL*

4. USUAL RESIDENCE Where deceased lived. If institution, residence before admission)  
A. STATE B. COUNTY

*Md*  
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore 12-05*

D. STREET ADDRESS (If rural, give location)

*1715 Calvert St*

c. Length of stay in Baltimore

5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*male white*

8. DATE OF BIRTH 9. AGE (In years last birthday) 10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.

*11-28-22 27*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*MECH. ENGINEER SURFACE Comb. Corp*

11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?

*BALTIMORE, MD.*

13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME

*FRANCIS O'HARE*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*YES WORLD WAR II*

16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

*216-16-1098*  
*JOHNS HOPKINS HOSPITAL*

**CAUSE OF DEATH**

18. *173X*  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Chronic epithelioma*  
DUE TO *- primary site unknown*

INTERVAL BETWEEN ONSET AND DEATH  
*4 mos.*

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7/10*, 19*49*, to *10/8*, 19*50*, that I last saw the deceased alive on *10/8*, 19*50*, and that death occurred at *2:00* pm., from the causes and on the date stated above.

23A. SIGNATURE

*Thomas J. Walsh*

M. D.

23B. ADDRESS

*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED

*10-8-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*10/11/50*

24C. NAME OF CEMETERY OR CREMATORY

*National*

24D. LOCATION (City, town, or county) (State)

*Baltimore, Md.*

DATE RECEIVED BY LOCAL REGISTRAR

*OCT 10 1950*

REGISTRAR'S SIGNATURE

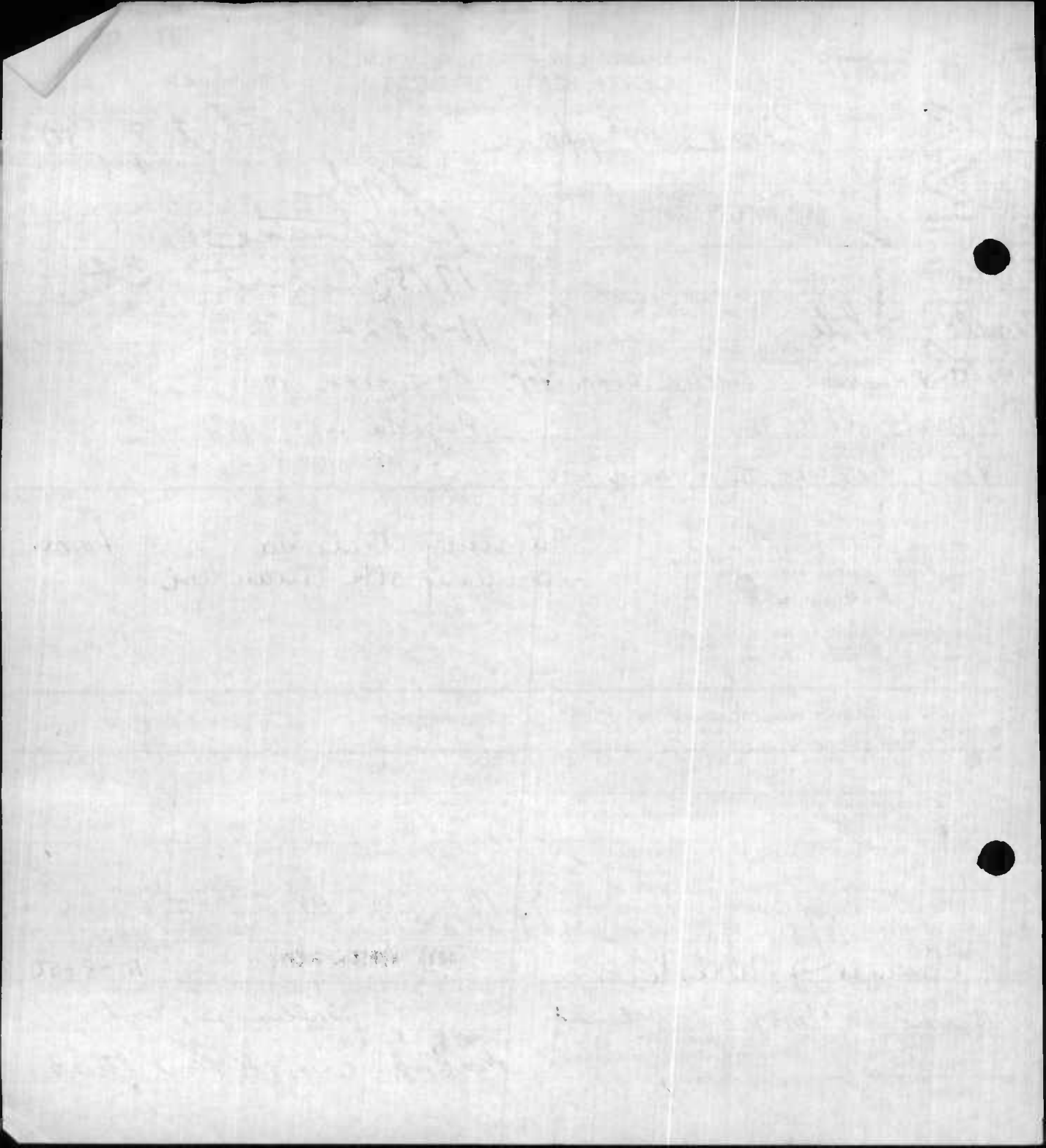
*Huntington Williams, Jr.*

25. FUNERAL DIRECTOR

*Stm. Cook, Inc. 1017 St. Paul Street*

ADDRESS

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**FRANK X. LEONARD**

2. DATE  
OF  
DEATH

**Oct. 8, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland **3017 Rosalie Avenue**

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland** B. COUNTY \_\_\_\_\_

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore** **27-05**

D. STREET ADDRESS (If rural, give location)  
**3017 Rosalie Avenue**

E. Length of stay in Baltimore **62** Yrs. Mos. Days

5. SEX

**Male**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**Married**

8. DATE OF BIRTH

**Dec. 14, 1887**

9. AGE (in years last birthday)

**62**

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Stock Clerk**

10B. KIND OF BUSINESS OR INDUSTRY

**Balto. News Post**

11. BIRTHPLACE (State or foreign country)

**Baltimore, Maryland**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**John J. Leonard**

14. MOTHER'S MAIDEN NAME

**Ellen A. Seward**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**No**

16. SOCIAL SECURITY NO.

17. INFORMANT

**Mrs. Gertrude M. Leonard**

ADDRESS

**3017 Rosalie Ave.**

18. **592x**

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Broncho Pneumonia**  
**Warmed**

**2 d.**  
**4 d.**

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Arterio Sclerosis**  
**Chronic Intestinal Hepatitis**

**3 mo.**  
**3 mo**

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **0**

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **OCT 1**, 19**50**, to **OCT 8**, 19**50**, that I last saw the deceased alive on **OCT 7**, 19**50**, and that death occurred at **6 a** m., from the causes and on the date stated above.

23A. SIGNATURE

**S. F. A. Stevens**

M. D.

23B. ADDRESS

**2878 Stanford Av**

23C. DATE SIGNED

**10-9-50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**Oct. 11, 1950**

24C. NAME OF CEMETERY OR CREMATORY

**Holy Redeemer**

24D. LOCATION (City, town, or county) (State)

**Baltimore, Maryland**

DATE RECEIVED BY LOCAL REGISTRAR

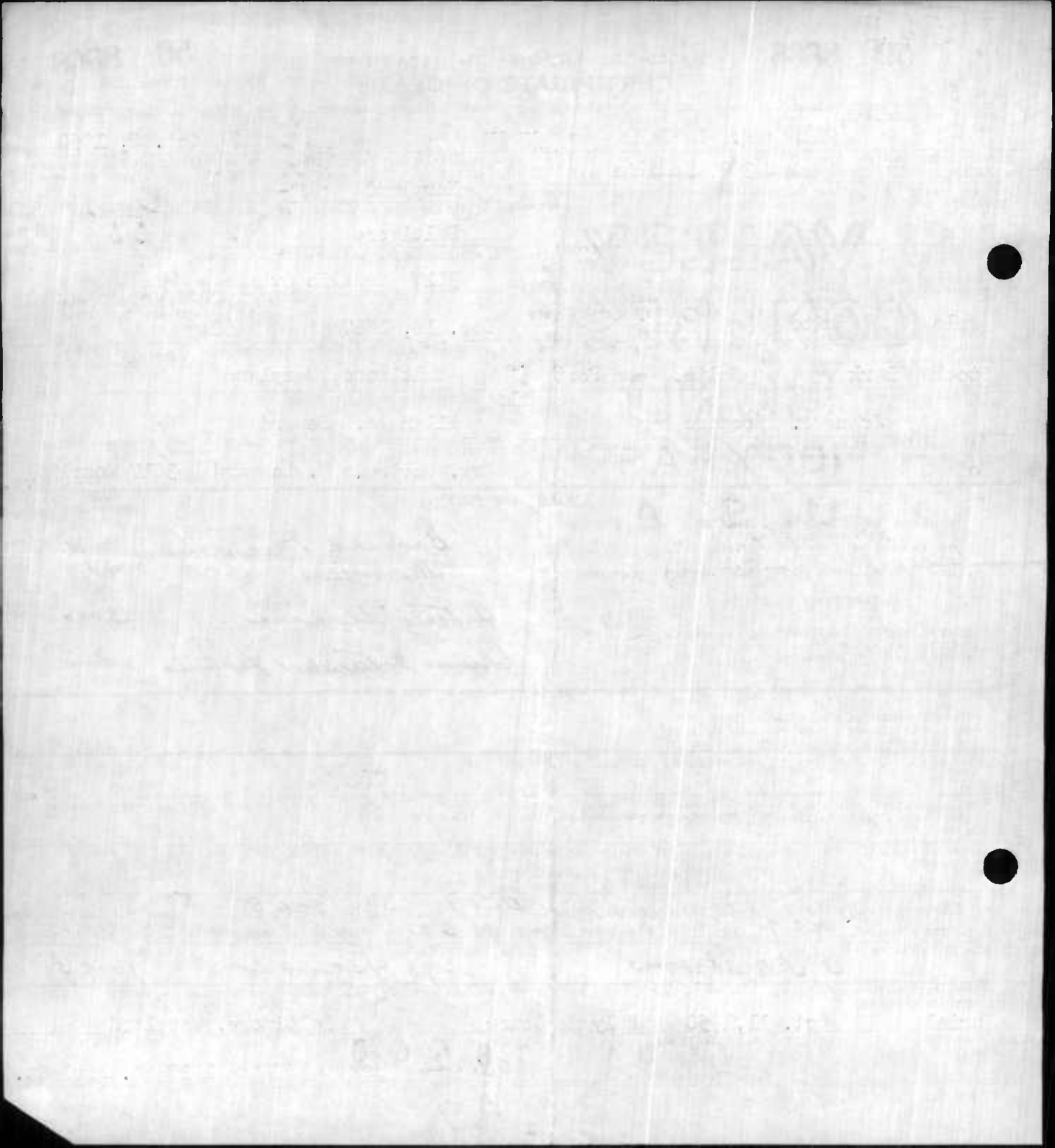
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

**William Cook, Inc.**

ADDRESS

**1217 St. Paul St.**



BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FRANK D. SIMMERS

2. DATE  
OF  
DEATH

Oct. 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1131 W. Lombard St.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 18-03

D. STREET ADDRESS (If rural, give location)

1131 W. Lombard Street

c. Length of stay in Baltimore

40 Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

March 2, 1879

9. AGE (In years  
last birthday)

71

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

Henry Danowitz Co.

11. BIRTHPLACE (State or foreign country)

Linville, Va.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Simmers

14. MOTHER'S MAIDEN NAME

Sarah Pifer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mary E. Simmers (wife) 1131 W. Lombard

18. 002 X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Polymyositis  
DUE TO

years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO  
(C)II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from Jan 1948 to Oct 7, 1950, that I last saw the deceased alive on Oct 7, 1950, and that death occurred at 942 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Charles Commello M. D.

940 W. Lombard St.

Oct. 9/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 10, 1950

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Huntington Williams, MD

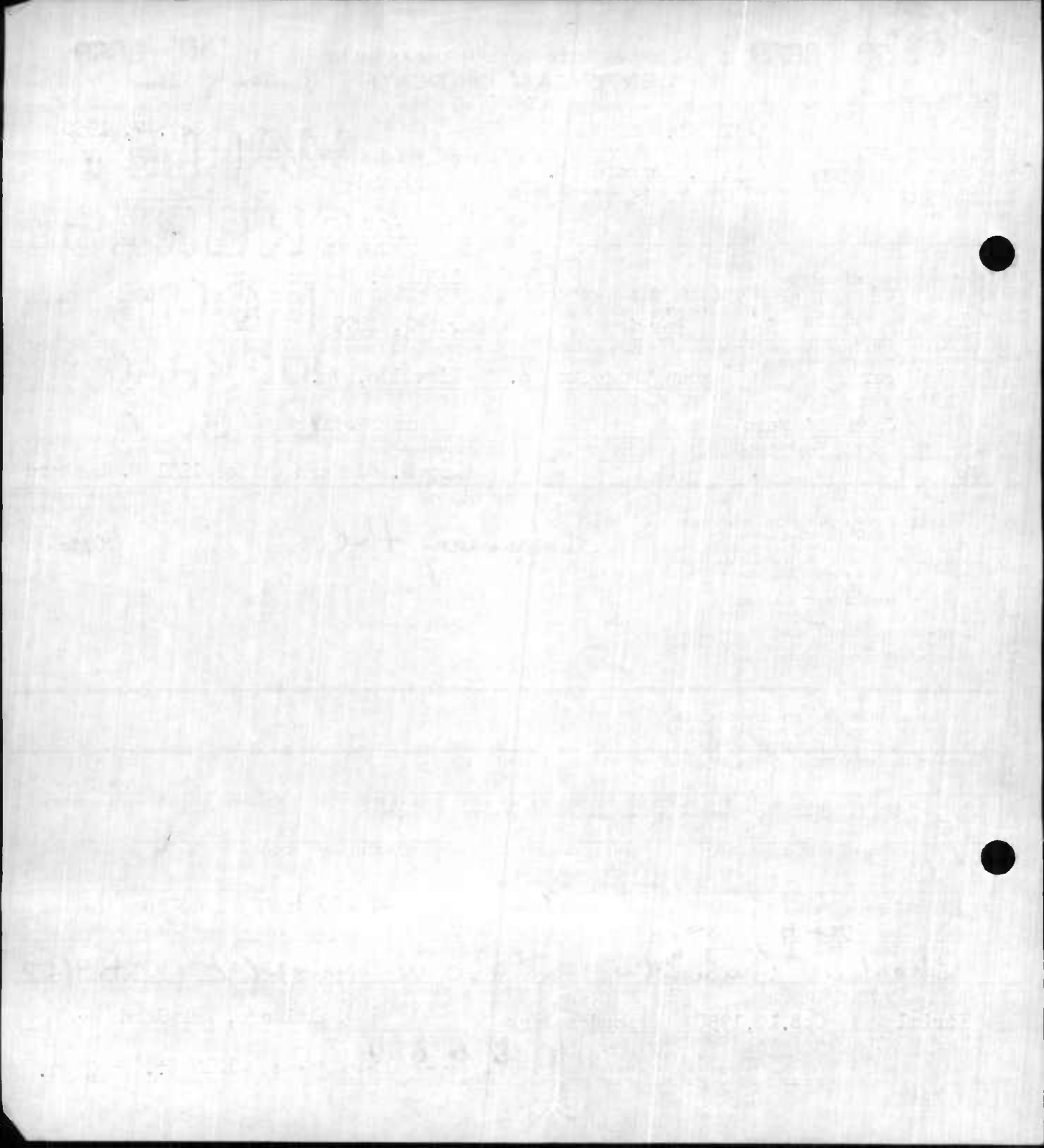
William Cook, Inc. 1217 St. Paul St.

OCT 10 1950

97063

0136

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 8670  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>FREDERICK T. STREEKS</b>			2. DATE OF DEATH <b>Oct. 9, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Lutnan Hospital &amp; Maryland</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto 15-12</b>		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>3627 Park Heights Ave</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widower</b>	B. DATE OF BIRTH <b>11/8/1887</b>	9. AGE (In years last birthday) <b>62</b>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Candy Mfr</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>	11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Charles Streeks</b>			14. MOTHER'S MAIDEN NAME <b>Mary (Unknown)</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Earl L. Streeks 3712 Chesolme Rd</b>		

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>R. Pontine Hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hypertensive Cardiovasc. Disease</b>			<b>2 yrs?</b>
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arteriosclerotic Cardiovasc. Disease</b>			
19A. DATE OF OPERATION <b>✓</b>		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Oct. 9, 1950</b> , to <b>October 9, 1950</b> that I last saw the deceased alive on <b>Oct. 9, 1950</b> , and that death occurred at <b>3:30 P.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>MH Edwards</b>		23B. ADDRESS <b>Lutnan Hosp. Md.</b>	23C. DATE SIGNED <b>10/9/50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/12/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	24D. LOCATION (City, town, or county) (State) <b>Woodlawn Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 10 1950</b>		25. FUNERAL DIRECTOR ADDRESS <b>Book Inc 1217 St. Paul St</b>	

0032

OFFICE OF THE SECRETARY OF DEFENSE

0032



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 8671

BIRTH NO. 240

1. NAME OF DECEASED (Type or Print) <b>WINIFRED D. BOSWELL</b>		2. DATE OF DEATH <b>Oct. 7, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>5112 Frederick Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 28-04</b>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>5112 Frederick Ave.</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>June 30, 1880</b>
9. AGE (In years last birthday) <b>70</b>		If Under 1 Year: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Samuel L. Dillinger</b>		14. MOTHER'S MAIDEN NAME <b>Kate Hutchinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Edward T. Boswell</b>		ADDRESS <b>5112 Frederick Av</b>	

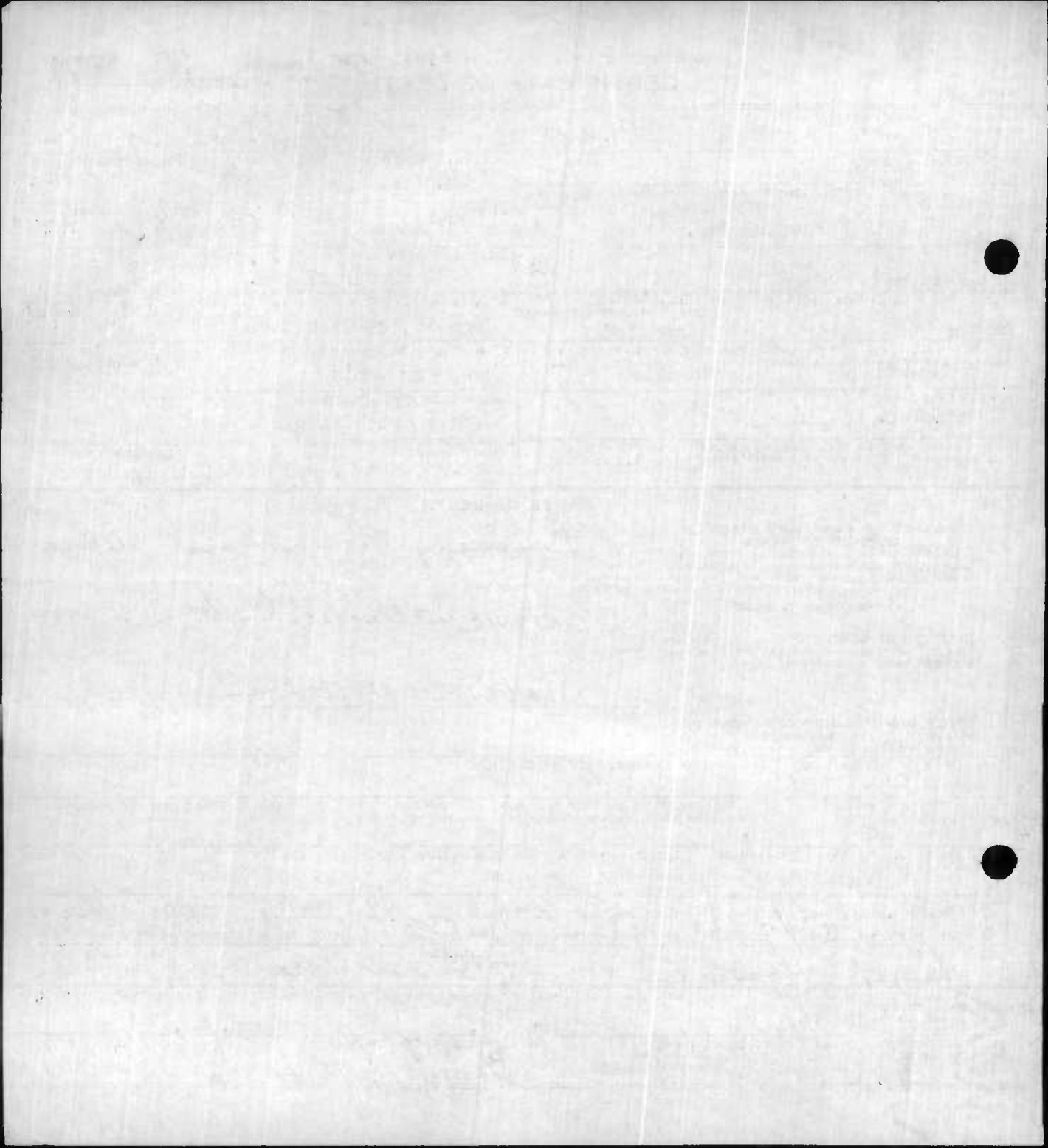
<p>18. <b>260X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p align="center"><b>CAUSE OF DEATH</b></p> <p>(A) <b>Coronary Thrombosis</b></p> <p>QUE TO</p> <p>(B) <b>Arterio Sclerotic C. V. S</b></p> <p>QUE TO</p> <p>(C) <b>Diabetes Mellitus</b></p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><b>6 hrs.</b></p> <p><b>2 mon.</b></p> <p><b>20 years</b></p>

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>0</b>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Aug 6, 1947 to Oct 7, 1950, that I last saw the deceased alive on Oct 7, 1950, and that death occurred at 8:35 A.M., from the causes and on the date stated above.

23A. SIGNATURE <b>James S. Howace</b>		23B. ADDRESS <b>715 Frederick Ave</b>		23C. DATE SIGNED <b>10-9-50</b>	
--	--	--	--	------------------------------------	--

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/11/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>Oct 7 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Wm. J. Dickner &amp; Sons - Balt. Md.</b>		ADDRESS	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**TERRELL H. CLARK**

2. DATE  
OF  
DEATH

**Oct. 8, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

**Md.**

B. FULL NAME OF (If not in hospital or institution, give street address or location)

**2917 N. Calvert St.**

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

**Baltimore**

**12-02**

D. STREET ADDRESS (If rural, give location)

**2917 N. Calvert St.**

E. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

**male**

6. COLOR OR RACE

**white**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**divorced**

8. DATE OF BIRTH

**Dec. 2, 1910**

9. AGE (In years last birthday)

**39**

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**engineer**

10B. KIND OF BUSINESS OR INDUSTRY

**Railroad**

11. BIRTHPLACE (State or foreign country)

**Indiana**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Harlan T. Clark**

14. MOTHER'S MAIDEN NAME

**Julia Harpster**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**yes**

**World War #2**

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**Mr. Harlan T. Clark - 2905 N. Charles St.**

18. **5614**

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Strangulated retroperitoneal hernia**

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

**Laceration of scalp with external hemorrhage**

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  
**Home**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

**2917 N. Calvert Street**

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

**October 1, 1950 ?**

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

**Apparently fell while suffering from strangulated hernia**

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

**Russell S Fisher**

M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

**10-8-50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**10/10/50**

24C. NAME OF CEMETERY OR CREMATORY

**Ft. Lincoln Cem.**

24D. LOCATION (City, town, or county)

**Prince George County, Md.**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

**OCT 10 1950**

REGISTRAR'S SIGNATURE

**Wm. J. Vickers**

25. FUNERAL DIRECTOR

**Wm. J. Vickers & Sons - Balt.**

ADDRESS





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

MARTHA ANN BROWN

2. DATE  
OF  
DEATH

Oct. 9, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

2905 Presstman St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

1105 Dukeland St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
widowed

8. DATE OF BIRTH

June 27, 1869

9. AGE (In years last birthday)

81

10 Under 1 Year  
Months: Days

11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
housewife

10B. KIND OF BUSINESS OR INDUSTRY  
at home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Noa H. Coulter

14. MOTHER'S MAIDEN NAME

Laura Jane Stahl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Burton C. Brown - 2905 Presstman St.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis, cardiac dilatation 2 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Age, asthma, malnutrition -

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Oct. 10, 1948, to Oct. 9<sup>th</sup>, 1950, that I last saw the deceased alive on Oct. 8, 1950, and that death occurred at 6A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Harry S. McCarty

M. D.

37 W. Cheston Street

10/9/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/11/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Livingston Williams, M.D.

8/Am. J. Lickner & Sons - Balto. Md.

1941

1941

RECEIVED - 1941

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RECEIVED - 1941

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

JOHN H. MOXLEY

2. DATE OF DEATH  
Oct. 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2803 Overland Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-02

D. STREET ADDRESS (If rural, give location)

2803 Overland Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

Nov. 3, 1867

9. AGE (in years last birthday)

82

10 Under 1 Year Months Days  
11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Reuben B. Moxley

14. MOTHER'S MAIDEN NAME

Amanda Howard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT ADDRESS  
Mrs. J. H. Moxley 2803 Overland Ave.

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*Cerebral Haemorrhage*

*2 days*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

*Generalized Arteriosclerosis*

*10 yrs.*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *June 13, 1943* to *Oct 7, 1950*, that I last saw the deceased alive on *Oct. 7, 1950*, and that death occurred at *4 P. m.*, from the causes and on the date stated above.

23A. SIGNATURE

*George Sawyer*

M. D.

23B. ADDRESS

*4808 Harford Rd.*

23C. DATE SIGNED

*10/9/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/10/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cem.

24D. LOCATION (City, town, or county) (State)

Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Thurston B. Williams, M.D.*

25. FUNERAL DIRECTOR

*Wm. J. Dickner & Sons - Balto. Md.*

ADDRESS

WALLEY  
CONGALLES

-360  
AB-142192

50

8675

BALTIMORE CITY HEALTH DEPARTMENT

50

8675

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Robert Paul Dutrey

2. DATE  
OF  
DEATH

10-9-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)Baltimore City Hospitals  
4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Essex

zone 21

(Rural)

D. STREET ADDRESS (If rural, give location)

418 Margaret Ave.

5300

C. Length of stay in Baltimore

1 yr.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec. 1-1924

9. AGE (In years  
last birthday)

25

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

APP-STEELWORKER

10B. KIND OF BUSINESS OR  
INDUSTRY

STEEL

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Paul Dutrey

14. MOTHER'S MAIDEN NAME

Elizabeth Kost

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT Baltimore City Hospitals  
Records: 4940 Eastern Ave.

18. 080.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Polioyelitis (spino-bulbar)

DUE TO

6 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

10-3-1950

19B. MAJOR FINDINGS OF OPERATION

Tracheotomy

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-3-1950 to 10-9-1950, that I last saw the  
deceased alive on 10-9-1950, and that death occurred at 4:50 PM., from the causes and on the date stated above.

23A. SIGNATURE

R. S. Ogden M.D.

23B. ADDRESS

Baltimore City Hospitals  
4940 Eastern Ave.

23C. DATE SIGNED

10-9-1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

10/12/50

24C. NAME OF CEMETERY OR CREMATORY

Westminster

24D. LOCATION (City, town, or county)

Carlisle PA.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

614-01350

R. S. Ogden

25. FUNERAL DIRECTOR

J. H. Strong

ADDRESS

VS 150

614 3A

036.0

MEDICAL CERTIFICATION

Dr. R. L. Heath called

City traps 12-18 50. low.

They are not sure as yet

Call again in 2 weeks.

EW

From case record Bureau of Communicable Diseases  
12/18/50 ES



410 50 8676

BALTIMORE CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH

Registered No. 50 8676

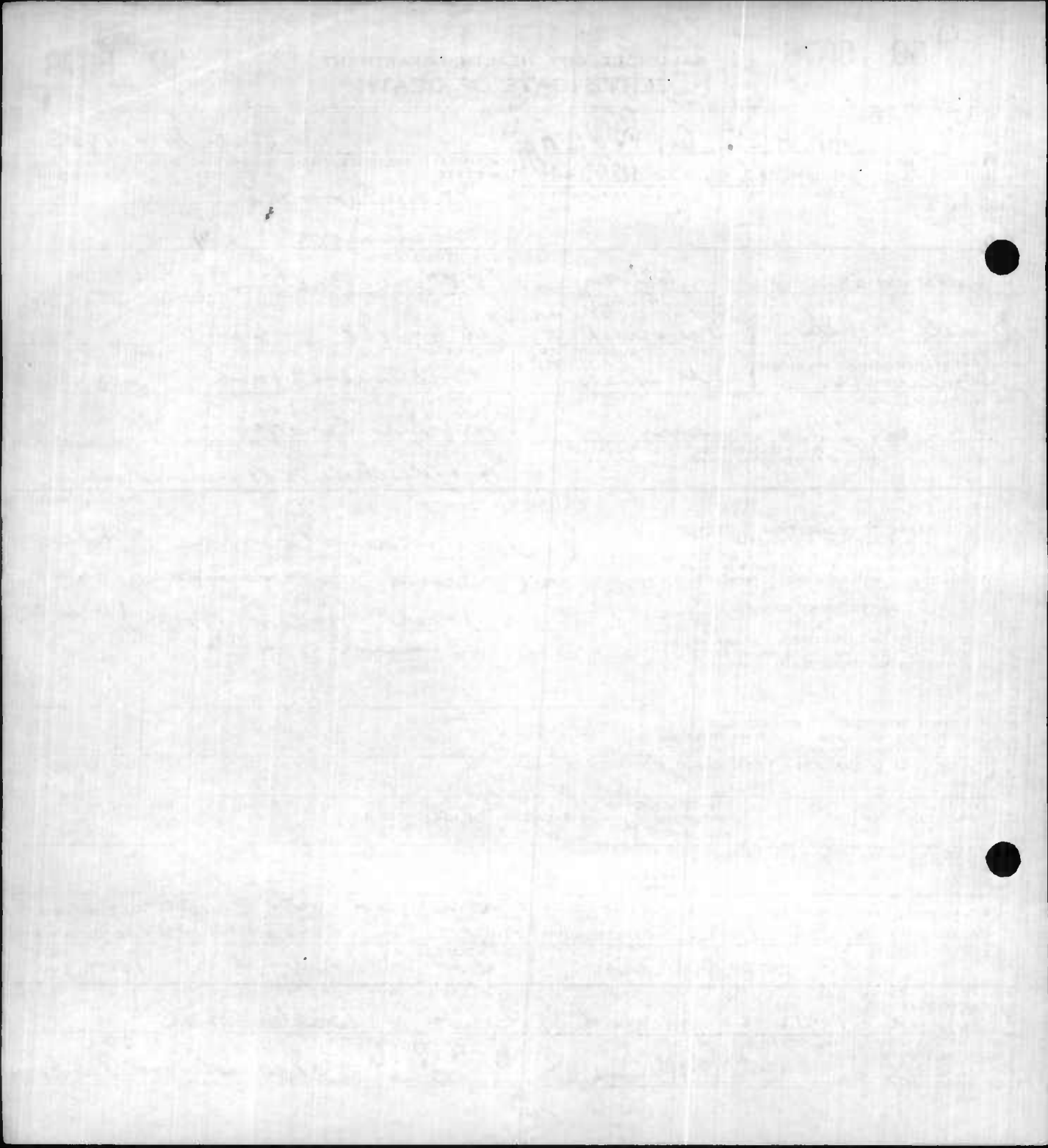
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GRACE G. WOLFE</b>		2. DATE OF DEATH <b>Oct 8-1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>882 W. Balt. St</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>18-01</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>62 yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>882 W. Baltimore St</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>Feb. 4-1888</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	9. AGE (In years last birthday) <b>62</b>
13. FATHER'S NAME <b>Warren Pearman</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Mollie Brooks</b>	
17. INFORMANT <b>Mrs. Blucher</b>		ADDRESS <b>501 W. Eldwood Park</b>	

MEDICAL CERTIFICATION	18. <b>422.1</b>	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			
	(A) <b>Pulmonary Edema</b> DUE TO <b>Prob. Intestinal Obstruction</b>			<b>4 day</b>
	(B) <b>Cerebral Hemorrhage</b> DUE TO <b>arteriosclerosis C.V.D.</b>			<b>10 month years</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>Jan. 1950 to Oct. 8, 1950</b> that I last saw the deceased alive on <b>Oct 7, 1950</b> , and that death occurred at <b>7 P.m.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>S. Highstein</b>		23B. ADDRESS <b>888 W. Lombard St.</b>		23C. DATE SIGNED <b>10-9-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-12-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Louison Park</b>	24D. LOCATION (City, town, or county) (State) <b>Bald. Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 10 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Williams, Jr.</b>		25. FUNERAL DIRECTOR <b>G. Jones</b>
				ADDRESS <b>501 W. Eldwood Park</b>

correct age is especially important. Physicians, please print the cause of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Josephine H. Kulezynski</i>		2. DATE OF DEATH <i>Oct 8 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore Md.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>2941 Hudson St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 1-01</i>	
c. Length of stay in Baltimore <i>55 yrs</i>		D. STREET ADDRESS (If rural, give location) <i>2941 Hudson St.</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>March 12-1889</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>61</i>
13. FATHER'S NAME <i>Bronislaw Ziemkowski</i>		11. BIRTHPLACE (State or foreign country) <i>Berlin Germany</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <i>Cecelia Lang</i>	
17. INFORMANT <i>Zygmunt R. Kulezynski</i>		ADDRESS <i>2941 Hudson St.</i>	

18. <i>151X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <i>Carcinoma of Stomach</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH <i>July 2/50</i>
---	--

19A. DATE OF OPERATION <i>8-2-50</i>	19B. MAJOR FINDINGS OF OPERATION <i>Inoperable carcinoma of Stomach</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>None</i>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>None</i>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>None</i>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>None</i>	21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <i>None</i>

22. I hereby certify that I attended the deceased from *July 2*, 19*50*, to *Oct 8*, 19*50*, that I last saw the deceased alive on *Oct 8*, 19*50*, and that death occurred at *9:00* A. M., from the causes and on the date stated above.

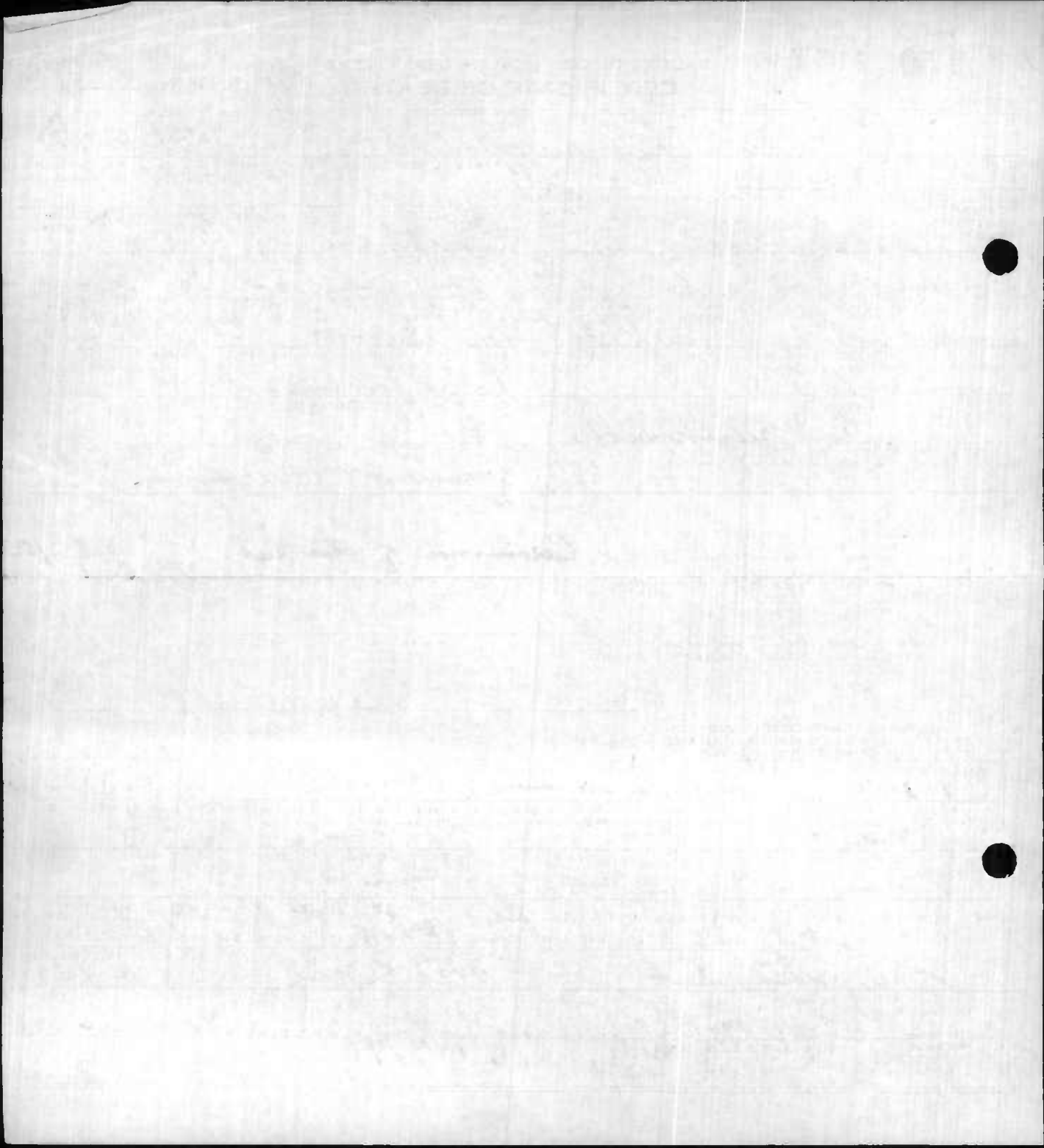
23A. SIGNATURE <i>S. G. Schimmuck</i>	M. D.	23B. ADDRESS <i>842 E. Eustace</i>	23C. DATE SIGNED <i>10-9-50</i>
--	-------	---------------------------------------	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Oct 11 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Holy Rosary Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>German Hill Road Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>Oct 11 1950</i>	REGISTRAR'S SIGNATURE <i>Wilmington Malianka, M.D.</i>	25. FUNERAL DIRECTOR <i>John J. Duda Inc</i>	
		ADDRESS <i>2829 Hudson St</i>	

OCT 11 1950

0461

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8678

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edward M. McCORMICK			2. DATE OF DEATH Oct. 8, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-20		
Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 2904 Taney Rd.		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 26, 1884	9. AGE (In years last birthday) 66	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Molder		10B. KIND OF BUSINESS OR INDUSTRY STOVES (M)	11. BIRTHPLACE (State or foreign country) Richmond, Virginia.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Edward Mc Cormack			14. MOTHER'S MAIDEN NAME Mae Beasley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. 212-07-2660	17. INFORMANT Ray McCormack		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			ADDRESS		

18. 001X	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) Pulmonary hemorrhage with pulmonary silicosis	
ANTECEDENT CAUSES		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Inspection & Inq.** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE Stanley B. Dunbar M.D.	23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	23C. DATE SIGNED Oct. 9, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Oct. 11, 1950	24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery
24D. LOCATION (City, town, or county) Woodlawn, Md.	24E. FUNERAL DIRECTOR Chas. J. Kenny-Inc. 1600 Hollins St.	24F. ADDRESS
DATE RECEIVED BY LOCAL REGISTRAR OCT 10 1950	REGISTRAR'S SIGNATURE Huntington Williams, Jr.	25. ADDRESS

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

100-100000-100000

TO : DIRECTOR, FBI (100-100000-100000)

FROM : SAC, NEW YORK (100-100000-100000)

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

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11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

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18. [Illegible]

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21. [Illegible]

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99. [Illegible]

100. [Illegible]



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Amy Goode</b>			2. DATE OF DEATH <b>10-8-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>1309 ARGYLE AVE.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 17. 17-02</b>		
C. Length of stay in Baltimore <b>YEARS</b>			D. STREET ADDRESS (If rural, give location) <b>1309 ARGYLE AVE.</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>Nov. 1863</b>		9. AGE (In years last birthday) <b>86</b> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>UNEMPLOYED</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>ALBERT GRAMMER</b>		
14. MOTHER'S MAIDEN NAME <b>JANE ?</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____ (If yes, give war or dates of service) _____		
16. SOCIAL SECURITY NO. _____			17. INFORMANT ADDRESS <b>MRS. SALLIE JOHNSON-1309 ARGYLE AVE</b>		

18. **450.0** CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**Arteriosclerosis**  
(A) \_\_\_\_\_ DUE TO \_\_\_\_\_  
INTERVAL BETWEEN ONSET AND DEATH  
**4 years.**

**CERTIFICATION APPROVED BY**

**Dr. John R. Davis**

per: \_\_\_\_\_

**CHIEF OR ASST. MEDICAL EXAMINER**

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <b>10-12-50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **10-8-1950** to **10-6-1950**, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_ and that death occurred at **10:40 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE <b>George C. Page</b> M. D.	23B. ADDRESS <b>1816 N. Mount St.</b>	23C. DATE SIGNED <b>10-10-50.</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>10-12-50.</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore 30., Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>W. A. Jackson</b>	25. FUNERAL DIRECTOR ADDRESS <b>W. A. JACKSON-916 PENNA. AVE.</b>	

10-2-01

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 8680

BIRTH NO. 600

1. NAME OF DECEASED (Type or Print) <u>Moore Walter Jefferson</u>			2. DATE OF DEATH <u>10/7/50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
5. FULL NAME OF (If not in hospital or institution, give street address or location) <u>Provident Hospital</u>			C. CITY OR TOWN <u>Baltimore</u> (If outside corporate limits, write RURAL and give township) <u>TOWSON-LENIX AVE</u>		
6. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <u>312 Lenox Avenue 5200</u>		
7. SEX <u>M</u>	8. COLOR OR RACE <u>C</u>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	10. DATE OF BIRTH <u>July 28 1862</u>		11. AGE (In years last birthday) <u>88</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>Talbot Co Md</u>
12. FATHER'S NAME <u>Omory Moore</u>			13. MOTHER'S MAIDEN NAME <u>Rebecca Johnson</u>		
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			15. SOCIAL SECURITY NO.		
16. INFORMANT			ADDRESS <u>Ruth Broom - 1515 David Hill Ave.</u>		

18. <u>177 X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) <u>Uremia</u>		DUE TO <u>Hypertensive heart disease</u>		<u>9-11-50</u>	
(B) <u>Uremia</u>		DUE TO <u>Metastatic prostatic carcinoma to bony pelvis, rectum</u>		<u>10-7-50</u>	
(C) <u>Uremia</u>				<u>(over)</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9-30-1</u> , 19 <u>50</u> , to <u>10-7-</u> , 19 <u>50</u> that I last saw the deceased alive on <u>10-7-</u> , 19 <u>50</u> , and that death occurred at <u>10:30</u> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <u>A. Nicola</u>		23B. ADDRESS <u>Provident Hospital</u>		23C. DATE SIGNED <u>10-8-50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10-11-50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY</u>	
24D. LOCATION (City, town, or county) (State) <u>A. A. Co. Maryland</u>		25. FUNERAL DIRECTOR <u>W. H. JACKSON - 916 PENNA. AVE.</u>			
DATE RECEIVED BY LOCAL REGISTRAR <u>Oct 10 1950</u>		REGISTRAR'S SIGNATURE <u>Wm. H. Jackson</u>		ADDRESS <u>W. H. JACKSON - 916 PENNA. AVE.</u>	

See Document File 50-8680  
2/20/51 ES

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH

JEROW

2. DATE  
OF  
DEATH

October 9, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

South Baltimore General Hosp.

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

9/29/1920

9. AGE (In years  
last birthday)

30

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR  
INDUSTRY

Produce Market

11. BIRTHPLACE (State or foreign country)

Summerton-S.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Henry Jerow

14. MOTHER'S MAIDEN NAME

Mattie Durant

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mattie Jerow-136-W. Hamburg Street

18. 434.3

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Chronic empyema

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Cardiac hypertrophy

DUE TO

(C) Chronic passive congestion, viscera

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....23C. DATE SIGNED  
10-9-5024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Removal

24B. DATE

10/13/50

24C. NAME OF CEMETERY OR CREMATORY

Sumter, S.C.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

William Henry Gable Ward

2. DATE  
OF  
DEATH

October 9, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's Hospital

C. Length of stay in Baltimore

53

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan. 13, 1897

9. AGE (In years last birthday)

53

If Under 1 Year Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Guard

10B. KIND OF BUSINESS OR INDUSTRY

Armco Steel Corp.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George W. Ward

14. MOTHER'S MAIDEN NAME

Amanda E. Orem

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW I

16. SOCIAL SECURITY NO.

218-14-5571

17. INFORMANT

ADDRESS

Myrtle G. Ward 400 Folsom St.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary thrombosis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Coronary artery disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10/6/1950, to 10/9/1950, that I last saw the deceased alive on 10/9/1950, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

E. Paul Coffey Jr.

M. D.

23B. ADDRESS

1400 N. Caroline Street

23C. DATE SIGNED

10/9/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 12, 1950

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

10/10/1950

Myrtle G. Ward

Myrtle G. Ward

1400 S. Chas. St.

VS 150

7633D

094a

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Etta May Riegger</b>			2. DATE OF DEATH <b>October 8, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>1319 W. 41st Street</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 13-08</b>		
C. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>1319 W. 41st Street</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>October 28, 1898</b>		9. AGE (In years last birthday) <b>51</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>John S. Haines</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>---</b>		
17. INFORMANT <b>Christian A. Riegger</b>			ADDRESS <b>1319 W. 41st Street</b>		

18. <b>154x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <b>Carcinoma of Rectum</b> DUE TO <b>Metastases to pelvis</b> (B) _____ DUE TO _____ (C) _____	INTERVAL BETWEEN ONSET AND DEATH <b>June 15/50 to Oct 8/50</b>
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19A. DATE OF OPERATION <b>June 28/50</b>	19B. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Rectum</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **June 15, 1950**, to **Oct 8, 1950**, that I last saw the deceased alive on **Oct 8, 1950** and that death occurred at **12:48 P. m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>Leonard Wallensten</b>	23B. ADDRESS <b>848 N 36th St</b>	23C. DATE SIGNED <b>10/9/50</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Oct. 11, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>
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DATE RECEIVED BY LOCAL REGISTRAR <b>Oct 10 1950</b>	REGISTRAR'S SIGNATURE <b>Walter H. Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Burges Funeral Home</b>	ADDRESS <b>3631 Falls Road</b>
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*Horace F. Burges*

046d

MEDICAL CERTIFICATION

October 2, 1950

John A. Blumenthal

Blumenthal

John A. Blumenthal

John A. Blumenthal

October 2, 1950

Blumenthal

John A. Blumenthal

John A. Blumenthal

Blumenthal Co., Maryland

John A. Blumenthal

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Fannie Wilson</b>		2. DATE OF DEATH <b>October 8, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>1366 N. Stricker St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto.</b> <b>15-01</b>	
C. Length of stay in Baltimore <b>?</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1366 N. Stricker St.</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>W</b>	8. DATE OF BIRTH <b>Feb. 18, 1893</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unemployed</b>		9. AGE (in years last birthday) <b>57</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Northumberland, Co. Va.</b>	
13. FATHER'S NAME <b>M. Ball</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Martha Norris</b>		ADDRESS <b>1366 N. Stricker St.</b>	

MEDICAL CERTIFICATION	18. <b>442 x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cardio-renal-vascular disease</b>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
	ANTECEDENT CAUSES	(A) DUE TO	CERTIFICATION APPROVED BY <b>Dr. John Davis</b> per <b>B. F. Fisher</b> M.D. CHIEF OR ASST. MEDICAL EXAMINER
	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) DUE TO	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>10-8-1950</b> to <b>10-8-1950</b> , that I last saw the deceased alive on _____, 19____, and that death occurred at <b>4:25 p.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>George B. Page</b>		23B. ADDRESS <b>1816 N. Mount St.</b>		23C. DATE SIGNED <b>10-10-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 12, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>	
24D. LOCATION (City, town, or county) <b>Md.</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 10 1950</b>		24F. REGISTRAR'S SIGNATURE <b>Thurston Williams, Jr.</b>	
24G. FUNERAL DIRECTOR <b>Geo. G. Nelson</b>		24H. ADDRESS <b>1303 Presstman St.</b>		24I. SIGNATURE <b>Geo. H. Nelson</b>	

100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098

67-01-61



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **3698**

BIRTH NO.

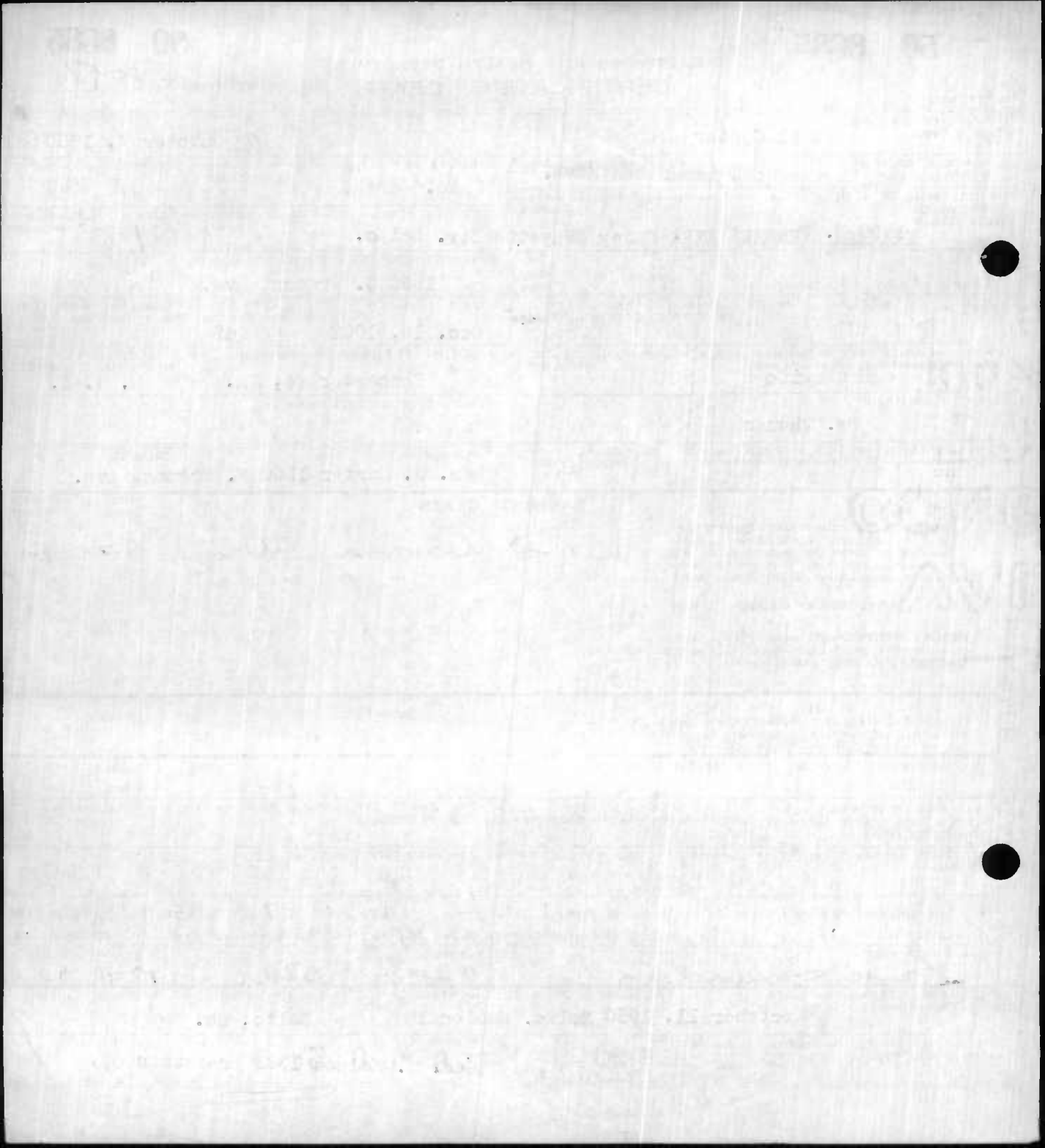
1. NAME OF DECEASED (Type or Print) <b>Ethel Carter</b>		2. DATE OF DEATH <b>October 7, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Good Samaritan Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>1560 N. Fremont XXXX Carey &amp; Fayette Sts. Balto.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>15-01</b>	
D. STREET ADDRESS (If rural, give location) <b>1560 N. Fremont Ave.</b>		5. LENGTH OF STAY IN BALTIMORE <b>?</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>Dec. 16, 1902</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <b>47</b>
13. FATHER'S NAME <b>Wm. Thomas</b>		11. BIRTHPLACE (State or foreign country) <b>Lancaster Co, Va.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT ADDRESS <b>Wm. J. Carter 1560 N. Fremont Ave.</b>	

**CAUSE OF DEATH**

18. <b>171X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <b>Carcinoma uteri</b> DUE TO (B) DUE TO (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH <b>About 2 yrs</b>
---	--

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>1-23</b> , 19 <b>44</b> , to <b>10-7</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>10-6</b> , 19 <b>50</b> , and that death occurred at <b>2:30 pm.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Frank A. Saunders</b>		23B. ADDRESS <b>1029 N. Stricker St.</b>		23C. DATE SIGNED <b>10-10-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>October 11, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balto. National</b>	
				24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	

DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>Wm. J. Carter</b>		25. FUNERAL DIRECTOR <b>Geo. G. Nelson</b>	
				ADDRESS <b>1393 Presstman St.</b>	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*William Lee*

2. DATE  
OF  
DEATH

*Oct. 8 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*Baltimore Md.*

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

*Franklin Square Hospital*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*Maryland*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Baltimore*

D. STREET ADDRESS (If rural, give location)

*109 N. Mount St*

C. Length of stay in Baltimore

5. SEX

*Male*

6. COLOR OR RACE

*Negro*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*Widowed*

8. DATE OF BIRTH

*June 2, 1888*

9. AGE (In years  
last birthday)

*62*

10 Under 1 Year  
Months: Days

11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

*Porter*

10B. KIND OF BUSINESS OR  
INDUSTRY

*Dept. Store*

11. BIRTHPLACE (State or foreign country)

*Maryland*

12. CITIZEN OF  
WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Andrew Hall*

14. MOTHER'S MAIDEN NAME

*Gertrude Churchhill*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

*Yes*

*WW I*

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

*Mrs. Estelle Prout. 109 N. Mount St.*

18. *420.0*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) *Acute coronary occlusion*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) *Atherosclerotic heart disease*

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the  
deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23A. SIGNATURE

*L. L. Tury Tury*

23B. ADDRESS

*Franklin Square Hospital. 10/8-5*

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

*Burial*

*Oct 11, 1950*

DATE RECEIVED BY  
LOCAL REGISTRAR

*OCT 10 1950*

REGISTRAR'S SIGNATURE

*H. H. Williams*

VS 150

24C. NAME OF CEMETERY OR CREMATORY

*National Cemetery*

24D. LOCATION (City, town, or county)

*Baltimore, Md.*

(State)

25. FUNERAL DIRECTOR

*Mrs. H. H. Williams*

ADDRESS

*322 N. Schroeder St*

*7806C*

*093d*

MEDICAL CERTIFICATION

W.M.T. 254

J-525

LC 141135

8687

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 8687

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Dangerfield Jenkins

2. DATE  
OF  
DEATH

Oct. 7 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION Baltimore City Hospitals

4940 Eastern Ave.

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1341 Pennsylvania Ave.

Length of stay in Baltimore

22 Yrs.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Mar. 17, 1887

9. AGE (In years

last birthday)

63

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Fleet Jenkins (D)

14. MOTHER'S MAIDEN NAME

Rosa Anna Fisher (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Records Baltimore City Hosp.  
4940 Eastern Ave.

18. 151X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Carcinoma of Stomach

DUE TO

2 1/2 yrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Carcinomatosis

DUE TO

2 1/2 yrs.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

Dec. 1948

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of Stomach

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 29, 1950, to Oct. 7, 1950, that I last saw the  
deceased alive on Oct. 7, 1950 and that death occurred at 3 PM, from the causes and on the date stated above.

23A. SIGNATURE

*[Signature]*

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

10-9-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 11, 1950

24C. NAME OF CEMETERY OR CREMATORY

Family Lot

24D. LOCATION (City, town, or county)

Downing, Virginia

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*[Signature]*

25. FUNERAL DIRECTOR

ADDRESS

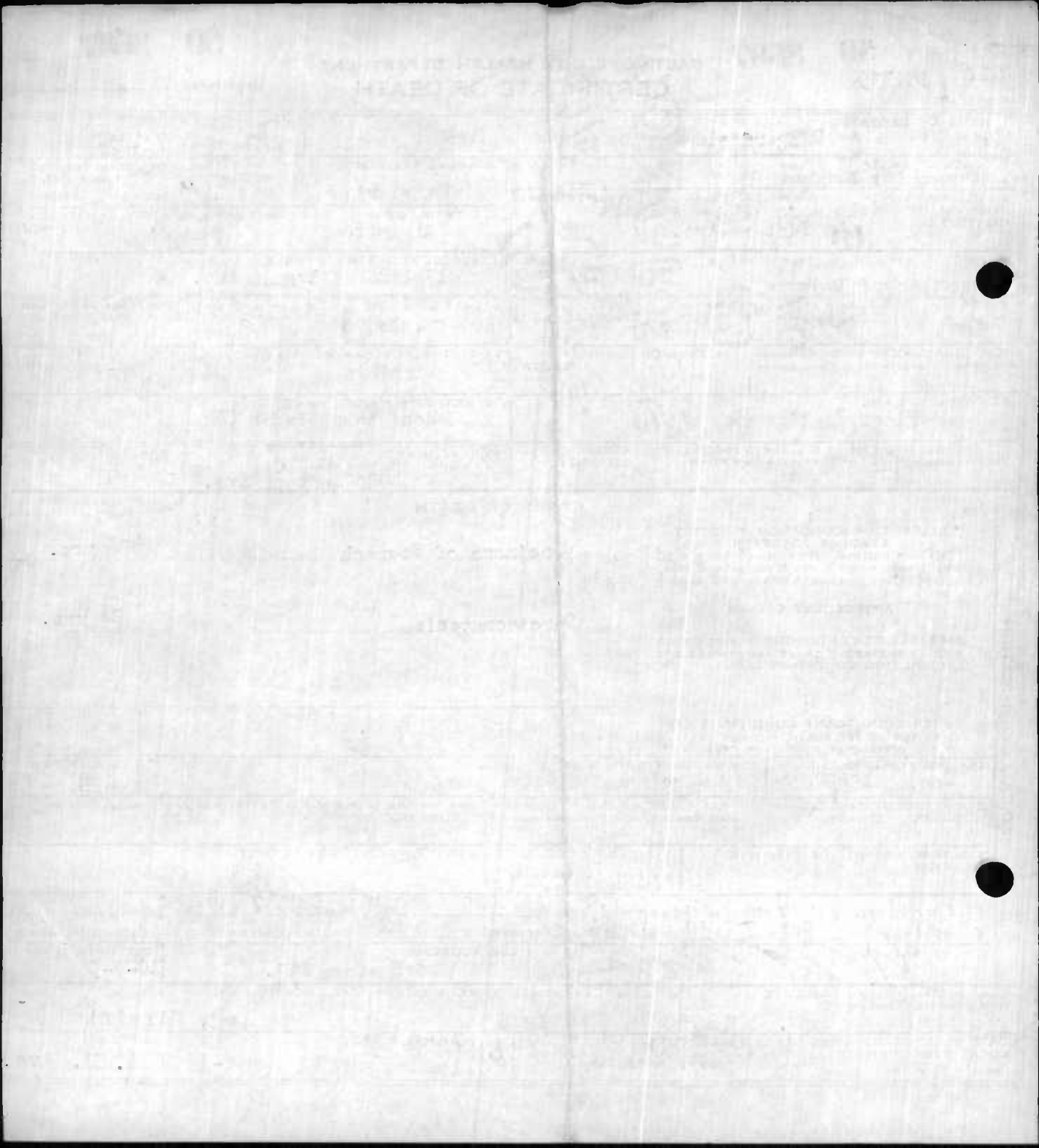
Holland Funeral Home-1631 D. H. Ave.

OCT 10 1950

VS 150

0466

MEDICAL CERTIFICATION





# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>WALTER WOOD KING</b>		2. DATE OF DEATH <b>October 9, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>D.C.</b> B. COUNTY <b>V-48</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR <b>US Marine Hospital</b> INSTITUTION <b>Wyman Pk. Drive &amp; 31st St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Washington</b>	
5. LENGTH OF STAY IN BALTIMORE <b>6 days</b>		O. STREET ADDRESS (If rural, give location) <b>2900 Connecticut Avenue</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>12/18/75</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Physician</b>	9. AGE (In years last birthday) <b>74</b>
13. FATHER'S NAME <b>Enoch King</b>		11. BIRTHPLACE (State or foreign country) <b>Ind.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or not known) (If yes, give war or dates of service) <b>?</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. SOCIAL SECURITY NO. <b>None</b>		14. MOTHER'S MAIDEN NAME <b>Alathair Hooper</b>	
17. INFORMANT <b>Records- US Marine Hospital, Balto, Md.</b>		ADDRESS	

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Encephalomalacia right cerebral, extensive.</b>	INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Coronary arteriosclerosis with infarction and mural thrombosis.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>10/10/50</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Oct. 3, 1950**, to **Oct. 9, 1950**, that I last saw the deceased alive on **Oct. 9, 1950** and that death occurred at **5:20 P. m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>John L. Wilson, Medical Director</b>	23B. ADDRESS <b>US Marine Hospital, Balto, Md.</b>	23C. DATE SIGNED <b>10/10/50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removed</b>	24B. DATE <b>10/10/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Washington Williams, Md.</b>
24D. LOCATION (City, town, or county) (State) <b>Wash. D. C.</b>	25. FUNERAL DIRECTOR <b>Joseph Carolus' Sons, 1756 Pa.</b>	

DATE RECEIVED BY LOCAL REGISTRAR  
**10/10/50**

REGISTRAR'S SIGNATURE  
**William Williams, Md.**

Correct age is especially important. Physicians, please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

# REPORT OF DEATH

October 3, 1950

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

D.C.

U.S. DEPARTMENT OF HEALTH

Washington

U.S. DEPARTMENT OF HEALTH

IN A COMMUNITARIAN MANNER

U.S. DEPARTMENT OF HEALTH

14

12/13/50

12/13/50

12/13/50

12/13/50

Alfred H. Hooper

Alfred H. Hooper

12/13/50 - 12/13/50 (12/13/50)

12/13/50

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12/13/50

H-652

50 8689

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8689  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

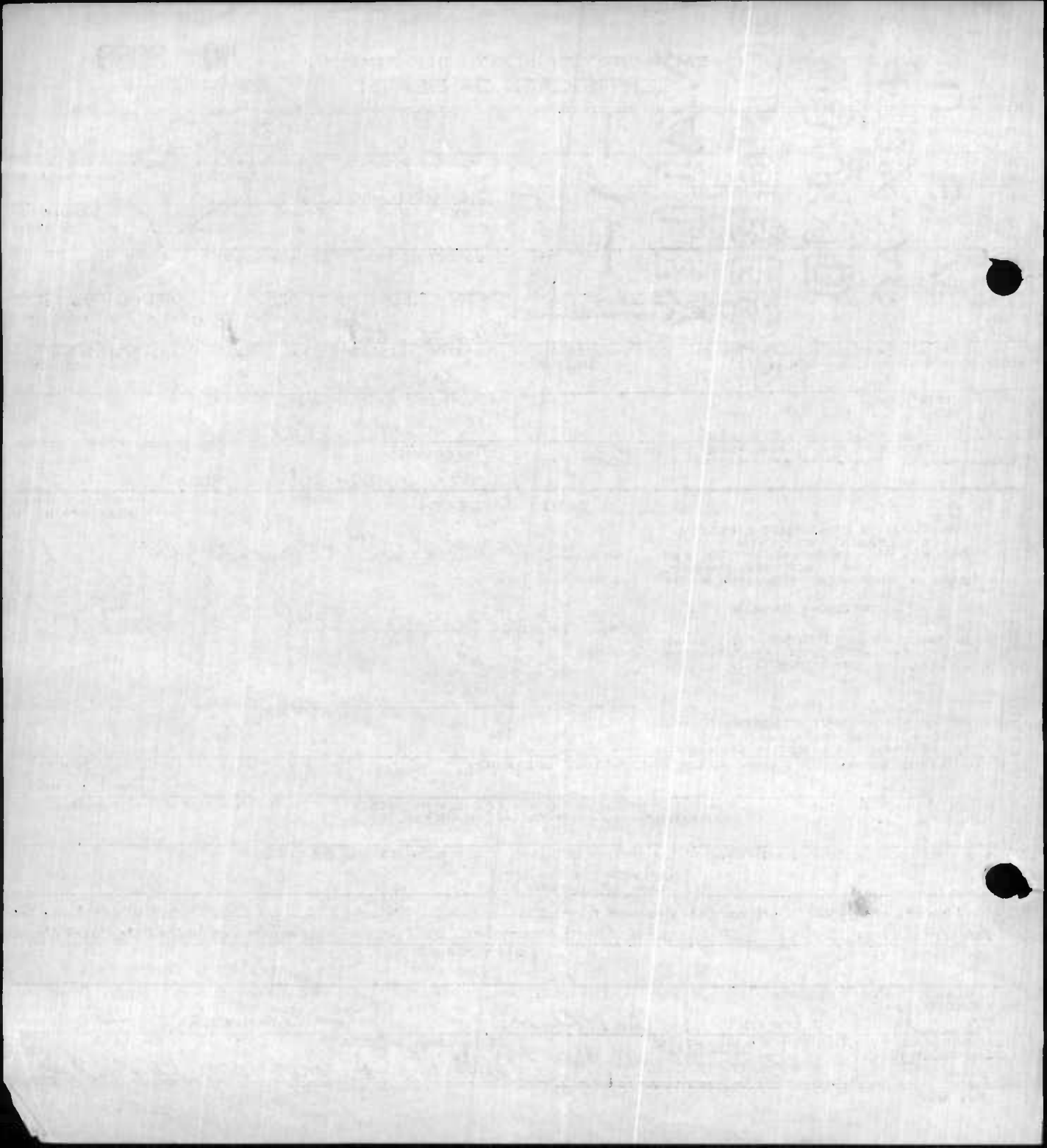
1. NAME OF DECEASED (Type or Print) <i>Frank Herring</i>		2. DATE OF DEATH <i>October 9, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1200 Valley Street</i>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Baltimore Md.</i> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Little Sisters of the Poor</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
Length of stay in Baltimore <i>11 yrs.</i>		D. STREET ADDRESS (If rural, give location) <i>10-01</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Nov. 12, 1873</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years: last birthday) <i>76</i>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	
13. FATHER'S NAME <i>William Herring</i>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <i>Isabelle Tabier</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Little Sisters of the Poor</i>	

18. <i>331X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.	CAUSE OF DEATH (A) <i>Cerebral Hemorrhage</i> DUE TO (B) <i>Arterio Sclerosis</i> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <i>9 days</i> <i>5 yrs</i>
--	---	---

19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Dec 1*, 1950, to *Dec 9*, 1950, that I last saw the deceased alive on *Dec 7*, 1950, and that death occurred at *7-10 P* m., from the causes and on the date stated above.

23A. SIGNATURE <i>E. Gill Hall M.D.</i>	23B. ADDRESS <i>1631 E. North Ave</i>	23C. DATE SIGNED <i>Dec 10 1950</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>10/12/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn</i>
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	25. FUNERAL DIRECTOR <i>H.M. Cook, Inc., 1217 St. Paul St.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 10 1950</i>	REGISTRAR'S SIGNATURE <i>Washington H. H. H.</i>	ADDRESS



A-260

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

MARY R. ASHER

2. DATE  
OF  
DEATH

10-9-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

5837 Belair Road

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 26-01

D. STREET ADDRESS (If rural, give location)

5837 Belair Road

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own home

13. FATHER'S NAME

Adolph Halzer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

(Yes, no or unknown)

16. SOCIAL SECURITY NO.

none

8. DATE OF BIRTH

Sept. 15, 1879

9. AGE (In years last birthday)

71

11 Under 1 Year 11 Under 24 Hours  
Months: Days Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Margaret O'Grady

17. INFORMANT

ADDRESS

Mrs. Mary R. Asher, 1708 Euter Place

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiovascular Disease

10 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-sclerosis - cerebral advanced

5 yrs

(C) Hypertension

10 yrs

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Duodenal Ulcer

15 yrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK NOT WHILE AT WORK

22. I hereby certify that I attended the deceased from Sept 23, 1950, to Sept 30, 1950, that I last saw the deceased alive on Sept 30, 1950, and that death occurred at 9 A m., from the causes and on the date stated above.

23A. SIGNATURE

C. S. S. M. D.

23B. ADDRESS

2074 E. Belvedere Ave.

23C. DATE SIGNED

10-9-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/10/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

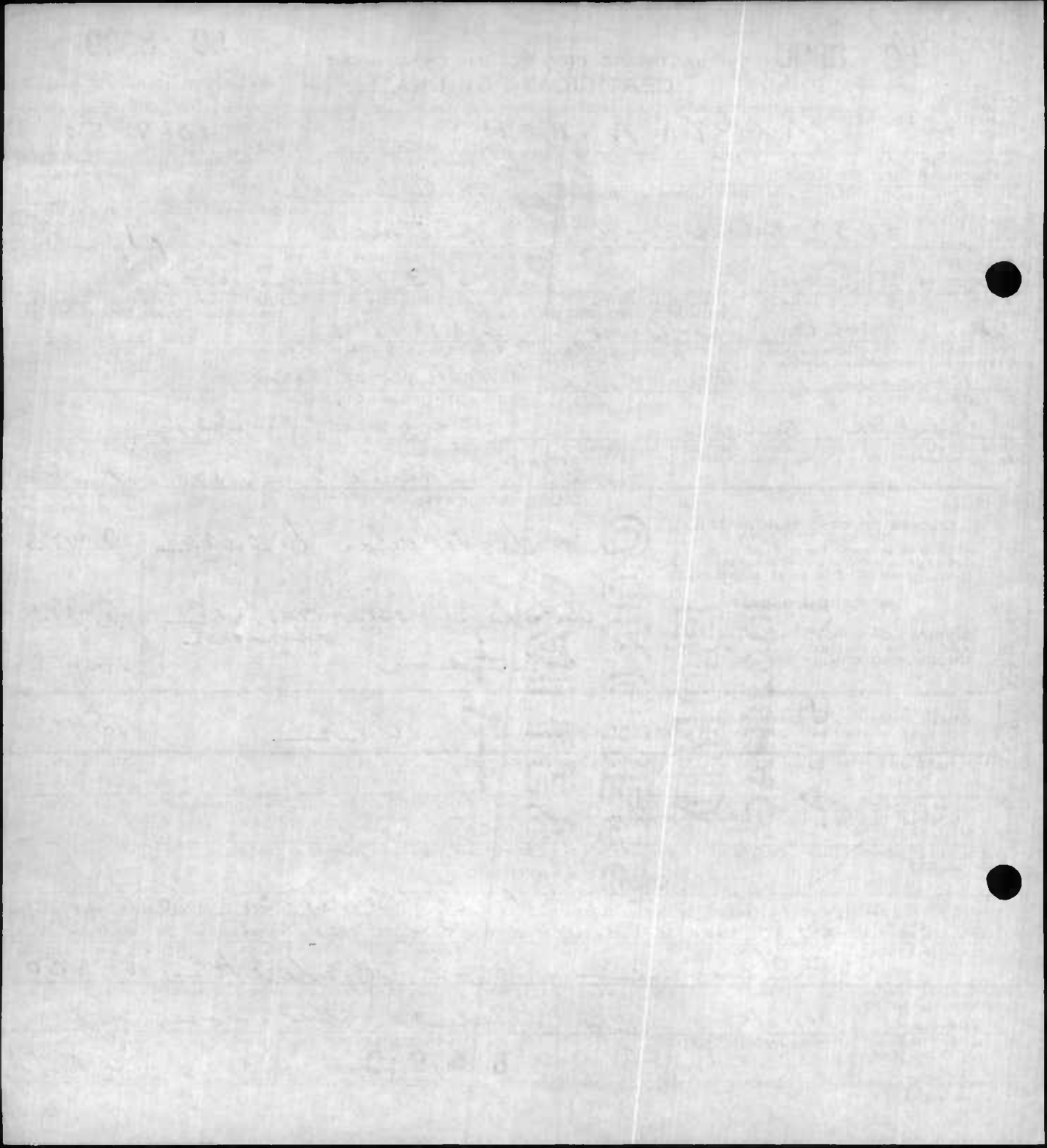
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

8 Wm. C. Cook, Inc., 1217 H. Paul St.





F-260.  
50 8691

50 8691

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Gottlob J. Fischer

2. DATE  
OF  
DEATH

Oct. 9, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

00 2121 W. Fayette St.

Length of stay in Baltimore 55 Yrs.

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2121 W. Fayette St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Baker

10B. KIND OF BUSINESS OR INDUSTRY

Alois Geier

13. FATHER'S NAME

Gottlob J. Fischer

8. DATE OF BIRTH

July 14, 1881

9. AGE (In years last birthday)

69

If Under 1 Year  
Months: Days

2

25

If Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Nina Schol

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL  
SECURITY NO.

220-09-6425

17. INFORMANT

ADDRESS

Mollie I. Fischer 2121 W. Fayette St

18. 420.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) .....

Arterio-sclerotic Heart Disease

2 wks

DUE TO

## ANTECEDENT CAUSES

(B) .....

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C) .....

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Rt. Hemiplegia

5 wks

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 23, 1950 to Oct 8, 1950, that I last saw the deceased alive on Oct 5, 1950, and that death occurred at 12:15 m., from the causes and on the date stated above.

23A. SIGNATURE

J. McCallum

M. O.

23B. ADDRESS

3321 Frederick Ave

23C. DATE SIGNED

10-9-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

10/11/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

876 P. A. W. 1913 W. Baltimore St.

OCT 15 1950

50044

093d

1022

1070

UNITED STATES OF AMERICA

OFFICE OF THE SECRETARY

1000 - 1000 - 1000

1000 - 1000 - 1000

1000 - 1000 - 1000

1000 - 1000 - 1000

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 8692**

BIRTH NO. **50 8692**

1. NAME OF DECEASED (Type or Print) <b>HATTIE TOPMAN</b>		2. DATE OF DEATH <b>October 7, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>11-03</b>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>438 St. Mary's Street</b>		C. CITY OR TOWN <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>438 St. Mary's Street</b>	
6. LENGTH OF STAY IN BALTIMORE Yrs. <b>11-03</b> Mos. <b>11-03</b> Days		8. DATE OF BIRTH <b>Sept. 3, 1897</b> 9. AGE (In years last birthday) <b>53</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b> 10B. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Charles Topman</b> 14. MOTHER'S MAIDEN NAME <b>Mary Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Frederick Topman 438 St. Mary St.</b>	

18. <b>422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>P. J. Lubinski</i>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. <input checked="" type="checkbox"/>		23C. DATE SIGNED <b>10-9-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-11-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. FUNERAL DIRECTOR <b>Francis A. Humley</b>		24F. ADDRESS <b>575 E. 11th St.</b>	

DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 10 1950</b>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR <b>Francis A. Humley</b>	
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1900

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5-365

50 8693

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8693  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Hampton MARY E. STERN

2. DATE  
OF  
DEATH

10-8-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 11-04

D. STREET ADDRESS (If rural, give location)

1324 McCulloh St

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

April 25, 1920

9. AGE (In years last birthday)

30

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

District of Columbia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Hampton Stern

14. MOTHER'S MAIDEN NAME

Ellen Todd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs Ellen Stern

ADDRESS

1324 McCulloh

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral Hemorrhage

20 Hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Hypertensive Ht. Disease

4 yrs

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10-7-50, 1950, to 10-8-50, 1950, that I last saw the deceased alive on 10-5-50, 1950, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

John H. Holmes III, M.D.

23B. ADDRESS

Provident Hosp.

23C. DATE SIGNED

10/9/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-12-50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Fredricksburg, Va.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. Francis A. Hummel

5480 Biddle St

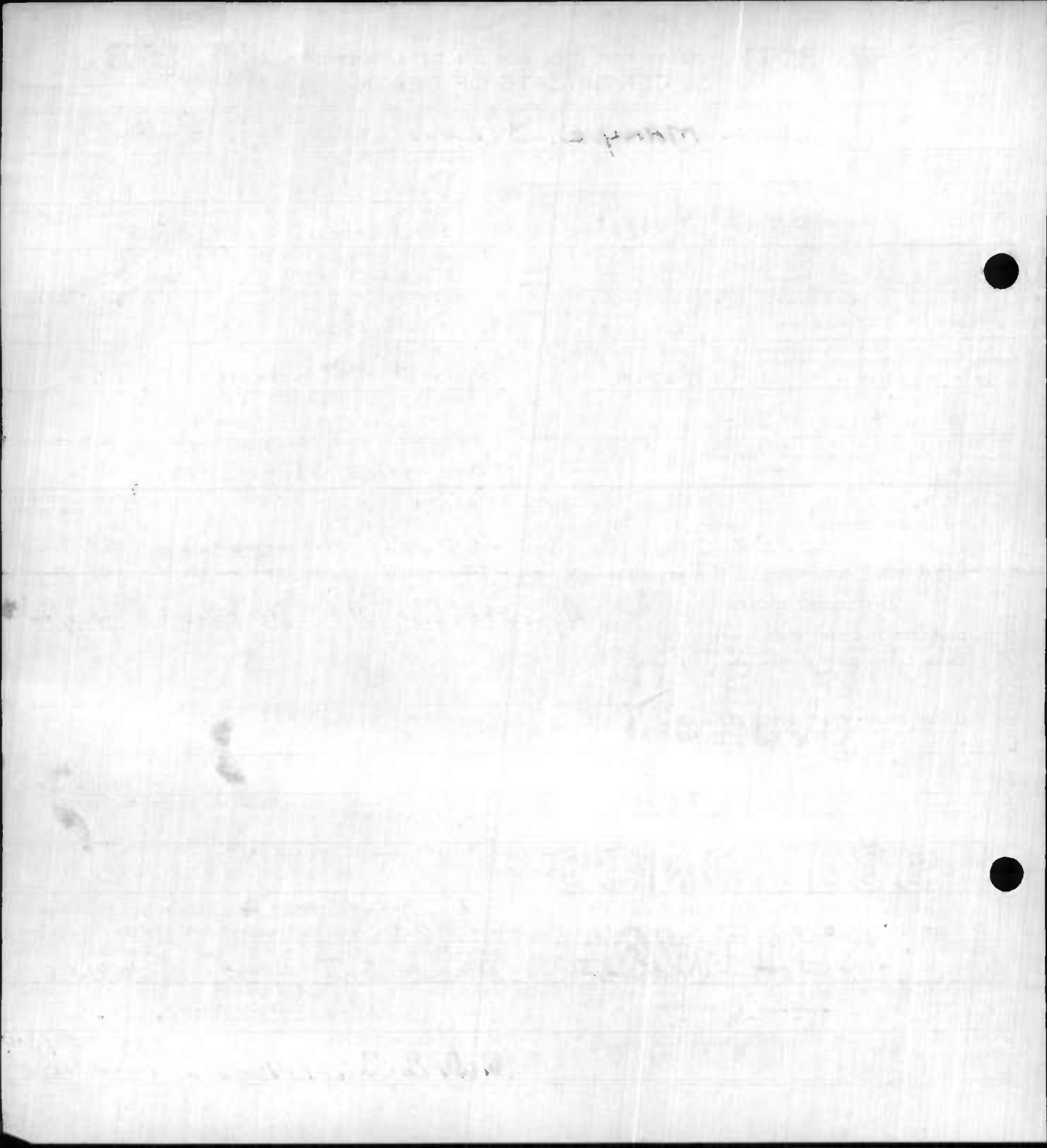
OCT 10 1950

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7208A

093d

Correct use is especially important. Physicians, please write the causes of death clearly and legibly.





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 8694  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print) *Walter Kendall*

2. DATE OF DEATH *10-7-50*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE *MARYLAND* B. COUNTY \_\_\_\_\_

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
*Provident Hospital*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore 17-01*

D. STREET ADDRESS (If rural, give location)  
*536 W. Biddle St*

Length of stay in Baltimore \_\_\_\_\_

5. SEX *Male* 6. COLOR OR RACE *Colored* 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *Single*

8. DATE OF BIRTH *7-11-40* 9. AGE (In years last birthday) *10* If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *School* 10B. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_

11. BIRTHPLACE (State or foreign country) *MARYLAND* 12. CITIZEN OF WHAT COUNTRY? *U. S. A*

13. FATHER'S NAME  
*William MacHeader*

14. MOTHER'S MAIDEN NAME  
*Gussie Kendall*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) \_\_\_\_\_

16. SOCIAL SECURITY NO. \_\_\_\_\_

17. INFORMANT ADDRESS *Mr Gussie Kendall 536 W. Biddle St*

18. *E981X*  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  
*Gun shot wound of Chest with left Hemothorax*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH \_\_\_\_\_

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_

DUE TO \_\_\_\_\_

(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION \_\_\_\_\_

19B. MAJOR FINDINGS OF OPERATION \_\_\_\_\_

20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIB. UTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  
*storeroom of*

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
*424 W. Biddle St.*

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  
*Oct. 7, 1950 abt. 11:30 a.m.*

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?  
*Firearms*

22. I certify that I took charge of the remains described above, held an *Autopsy* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE  
*William V. Smith*

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ 23C. DATE SIGNED *Oct 11 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify)  
*Burial*

24B. DATE  
*10-12-50*

24C. NAME OF CEMETERY OR CREMATORY  
*Mt. Auburn*

24D. LOCATION (City, town, or county) (State)  
*Baltimore Md*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1922 21

DEPARTMENT OF HEALTH

1922

CERTIFICATE OF DEATH

Register No.

1922

1922

1922

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S-3508695

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 8695

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Joseph Samuel Stone

2. DATE  
OF  
DEATH

Oct. 8/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE\* (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1821 Ramsay St.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

60 1821 Ramsay St.

Length of stay in Baltimore 65 yrs

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 7, 1873

9. AGE (in years last birthday)

77

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clothing Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Warner &amp; Co.

13. FATHER'S NAME

Henry Stone

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Anna----

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Clara L. Stone, 1821 Ramsay St.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Coronary occlusion

3 mos

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

arterio sclerosis (generalized)

2 yrs

(C)

none

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(D)

none

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from June 1948 to Sept 8, 1950 that I last saw the deceased alive on 9/8, 1950 and that death occurred at 2:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Oct. 11/50

Loudon Park

3801 Frederick Rd. Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wilmington, Delaware

4101 Edmondson Ave.

FEDERAL BUREAU OF INVESTIGATION

U. S. DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20535

DATE: 10-10-78

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [REDACTED]

RE: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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5-612

50 8696

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8696

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

George Joseph Sarbacher

2. DATE  
OF  
DEATH

Oct. 8/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

312 S. Fulton Ave.

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

Yrs.  
Mos.  
Days

8. DATE OF BIRTH

Jan. 15, 1887

9. AGE (in years  
last birthday)

63

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Produce Salesman

10B. KIND OF BUSINESS OR  
INDUSTRY

(W)

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Sarbacher

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes World War 1

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Nellie Sarbacher, 312 S. Fulton Av

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

4 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from March 14, 1947, to Oct. 8, 1950, that I last saw the  
deceased alive on Oct. 7, 1950, and that death occurred at 10:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Oct. 12/50

New Cathedral, 4300 Old Frederick Rd. Balto. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

OCT 10 1950

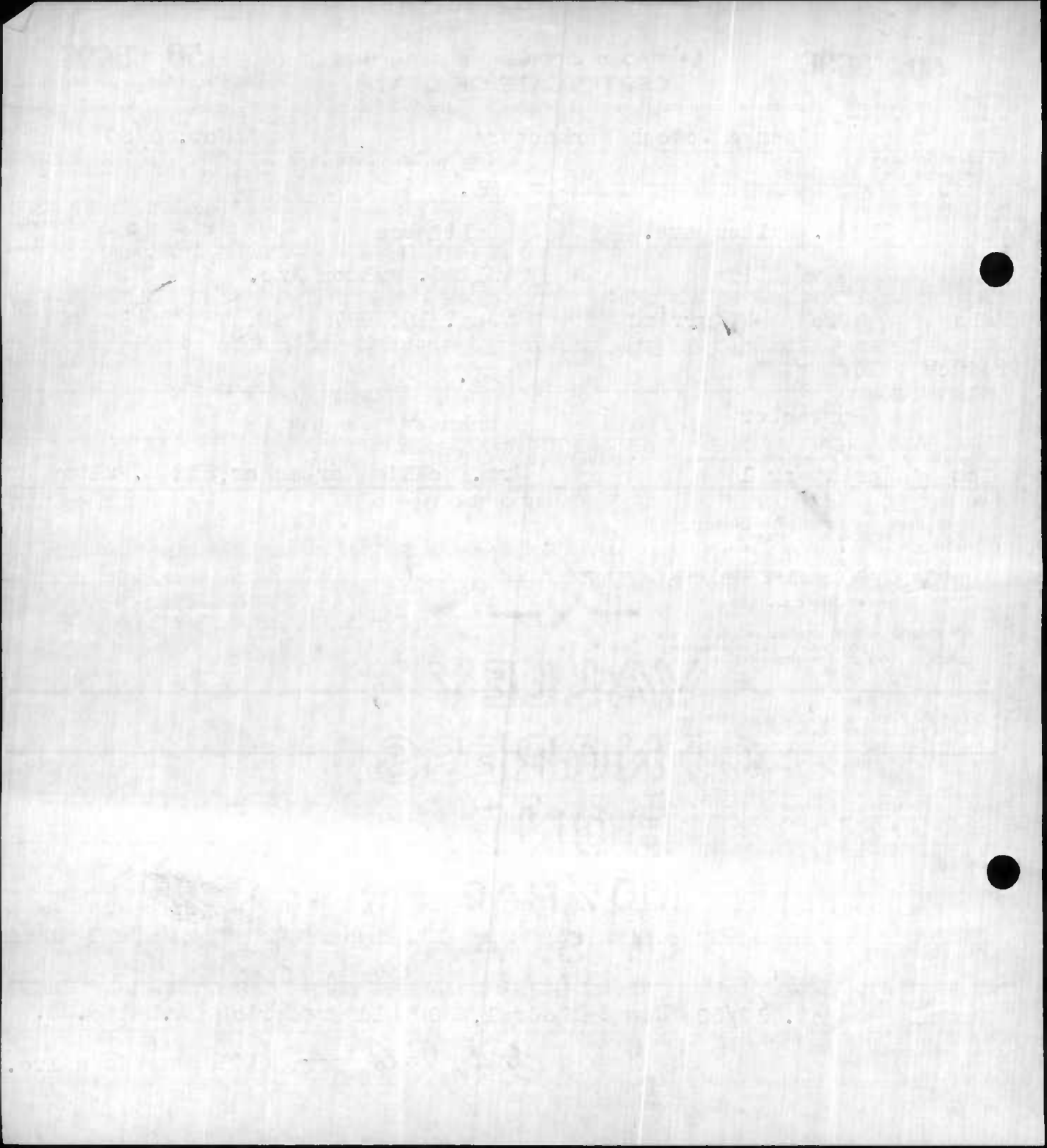
Huntington Williams, M.D.  
490 63

4101 Edmondson Ave.

094a

Collect age is especially important. Informants: please print the names of informants and register.

MEDICAL CERTIFICATION





M-650

50 8697

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8697

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Eugene W. Marron

2. DATE  
OF  
DEATH

Oct. 7/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

3200 Clifton Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3200 Clifton Ave.

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

Male

White

Married

Dec. 16, 1899

50

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Accountant

10B. KIND OF BUSINESS OR  
INDUSTRY

C.J. Benson &amp; Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Eugene O. Marron

14. MOTHER'S MAIDEN NAME

Annie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Thelma Marron, 3200 Clifton Ave

18. 163X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Carcinoma lung

6 mo

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from Aug 1, 1950, to Oct 7, 1950, that I last saw the  
deceased alive on Oct 6, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

J. S. Handberg

M. D.

23B. ADDRESS

3805 Selvi Rd

23C. DATE SIGNED

Oct 9/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Oct. 11/50

Woodlawn

Woodlawn, Balto. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 10 1950

J. S. Handberg, M.D.

J. S. Handberg

4101 Edmondson Ave.

VS 150

0006G

047d

correct age is especially important. Physicians, please write the cause of death and degree.

MEDICAL CERTIFICATION

1923

1923



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Jenny James

2. DATE  
OF  
DEATH

October 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Good Samaritan Hospital

C. Length of stay in Baltimore

30 Years

5. SEX

Female

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housekeeper

10B. KIND OF BUSINESS OR INDUSTRY

Domestic

13. FATHER'S NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

1423 Lombard St.

8. DATE OF BIRTH

Dec. 10, 1892

9. AGE (In years last birthday)

57 58

If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Unknown

17. INFORMANT

ADDRESS

Henry Williams 1423 Lombard St., Balt., Md.

18. 022X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Arteriosclerosis of aorta

4 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

over

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1950 to Oct 7, 1950, that I last saw the deceased alive on Oct 7, 1950, and that death occurred at 1:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

A. E. Burwell

M. D.

23B. ADDRESS

171 Reservoir Dr.

23C. DATE SIGNED

10-10-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 12, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county) (State)

Brooklyn, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Joseph L. Russ 1200 McEllish St.

720 FA

030d

Baltimore, Md.

MEDICAL CERTIFICATION

due to supplies?

"Synthetic"

See Document File 50-8698

10-18-50

ES

2-423 50 8699 **CERTIFICATE CORRECTED** 10-13-50  
BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH** Registered No. 50 8699

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Marcelo S DELGADO</b>		2. DATE OF DEATH <b>October 4, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Harford</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Edgewood Arsenal (Army Chemical Ctr.)</b>	
D. STREET ADDRESS (If rural, give location) <b>1st Chemical Service Battalion 6200</b>		E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>Jan. 17, 1917</b>
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>		9B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>	9. AGE (In years last birthday) <b>33</b> 32
10A. CITIZENSHIP (If naturalized, give date) <b>U.S.A.</b>		11. BIRTHPLACE (State or foreign country) <b>Philippine Islands</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>yes</b>		15. SOCIAL SECURITY NO. <b>at present</b>	
16. MOTHER'S MAIDEN NAME <b>Sancha S. Marcelas</b>		17. INFORMANT <b>Army Records, Army Chemical Center, Md.</b>	

18. <b>E819.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Skull fracture</b>		INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Fracture of first and second vertebrae</b> <b>Multiple fractures of mandible</b> <b>Comminuted fracture right femur</b>		

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., to or about home, farm, factory, street, office bldg., etc.) <b>highway</b>	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Pulaski Highway 700 feet west of Race Rd</b>		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>October 4, 1950 3.20a.m.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Passenger in car which ran into concrete culver</b>		
22. I certify that I took charge of the remains described above, held an <b>Inquiry &amp; Inspection</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .				

23A. SIGNATURE <b>William V. Howard</b>		23B. CHIEF MEDICAL EXAMINER M.D. <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24B. DATE <b>Oct 11, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	24D. LOCATION (City, town, or county) (State) <b>Arlington Va</b>	
25. DATE RECEIVED BY LOCAL REGISTRAR <b>Oct 10 1950</b>		25. REGISTRAR'S SIGNATURE <b>Howard K. McCombs</b>		
26. FUNERAL DIRECTOR <b>Howard K. McCombs</b>		ADDRESS <b>Abingdon Md 170c</b>		

MEDICAL CERTIFICATION

N 804.2

59591

Abingdon

Md 170c

100

100

CERTIFICATE OF DEATH

100

100





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Sister Mary Agnes (O'Leary)*

2. DATE  
OF  
DEATH

*10-9-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*Bon Secours Hospital*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*Sm. of N.D. de Namur, Trinity Preparatory*

Length of stay in Baltimore

5. SEX

*Female*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Single*

8. DATE OF BIRTH

*3-7-97*

9. AGE (In years last birthday)

*53*

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Religious*

10B. KIND OF BUSINESS OR INDUSTRY

*Teacher*

11. BIRTHPLACE (State or foreign country)

*Wash. D.C.*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Timothy O'Leary*

14. MOTHER'S MAIDEN NAME

*Mary Sheehan*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Trinity Convent Records*

18. *5810*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

*Rupture of Esophagic Varices*

ANTECEDENT CAUSES

*Biliary Cirrhosis of Liver*

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

*Xanthomatosis.*

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *10-7-1950*, to *10-9-1950*, that I last saw the deceased alive on *10-9-1950*, and that death occurred at *1:18 pm.*, from the causes and on the date stated above.

23A. SIGNATURE

*W. J. ...*

23B. ADDRESS

M. D.

*Bon Secours Hospital*

23C. DATE SIGNED

*10-9-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

*10-12-50*

24C. NAME OF CEMETERY OR CREMATORY

*Trinity Convent Cmn*

24D. LOCATION (City, town, or county)

*Whester, Ind*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Wm. J. Williams, M.D.*

25. FUNERAL DIRECTOR

ADDRESS

*827 1/2 E. ... Fulton St.*

OCT-1-50 950

0938V

1246

Correct age is especially important. Physicians please write the causes of death clearly and legibly.



B-450 8701

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8701  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William J. Bloom

2. DATE  
OF  
DEATH

10/18/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

St. Agnes Hospital

Length of stay in Baltimore

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Md. suburban 11-04

D. STREET ADDRESS (If rural, give location)

1242 Linden Ave #27

5. SEX

M.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Sept 11, 1908

9. AGE (In years last birthday)

42

If Under 1 Year Months: Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Capt. Fire Dept. Baltimore

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wm. J. Bloom

14. MOTHER'S MAIDEN NAME

Emma Rhine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Helen Bloom, 1242 Linden Ave.

18. 157X I

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)(A) CARCINOMA PANCREAS  
DUE TO GENERALIZED ABDOMINAL METASTASIS

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CACLEXIA  
DUE TOII  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10/7, 1950, to 10/8, 1950, that I last saw the deceased alive on 10/8, 1950, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 19 1950

76293

0469

MEDICAL CERTIFICATION

1078 52

1078 52

THE STATE OF NEW YORK  
IN SENATE

January 10, 1891

REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
JANUARY 10, 1891

ALBANY:  
J. B. LIPPINCOTT & CO. PRINTERS  
1891

THE STATE OF NEW YORK  
IN SENATE  
JANUARY 10, 1891

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*ELIZABETH C. WALTER*

2. DATE  
OF  
DEATH

*Oct. 7, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years  
last birthday)

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT ADDRESS

18. *154X*

**CAUSE OF DEATH**

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

*Carcinoma of Rectum*

*2 years*

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

*Carcinomatosis*

*1 year*

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *June*, 19*48*, to *Oct. 7*, 19*50*, that I last saw the deceased alive on *Oct. 7*, 19*50*, and that death occurred at *7 A* m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

*046 d*

MEDICAL CERTIFICATION

Content here is especially important. Physicians, please write the causes of death clearly and legibly.

30 8703

30 8703

DEATH CERTIFICATE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH



50 8703  
W-255  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8703  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>ALFRED</b>			WAGAMAN			2. DATE OF DEATH <b>October 10, 1950</b>				
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Pennsylvania</b> B. COUNTY <b>V-25</b>							
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Hanover</b>							
Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>R. F. D #4</b>							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>		8. DATE OF BIRTH <b>Nov. 26, 1929</b>		9. AGE (In years last birthday) <b>20</b>		If Under 1 Year Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Appr. Lockey</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Adams Co. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Phillip Wagaman</b>			14. MOTHER'S MAIDEN NAME <b>Edith Smith</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT <b>Edith S. Wagaman</b>			ADDRESS <b>Hanover Pa.</b>	

18. <b>E 902.4</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Fracture of base of skull</b>			
DUE TO					
ANTECEDENT CAUSES		(B) <b>Subdural hemorrhage</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
		(C) <b>Contusion of brain</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>race track</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Laurel Race Track, Laurel Maryland</b>	
21D. TIME (Month) (Day) (Year) (Hour) <b>October 6, 1950 11a. m.</b>		21E. INJURY OCCURRED WHILE AT <input checked="" type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell or thrown while exercising horse</b>	

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>William A. Feiser</b>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>10-10-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>10/13/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>McSherrystown Pa.</b>		24D. LOCATION (City, town, or county) (State) <b>Hanover, Pa.</b>	

DATE RECEIVED BY LOCAL REGISTRAR <b>Oct 10 1950</b>		REGISTRAR'S SIGNATURE <b>William A. Feiser</b>		25. FUNERAL DIRECTOR <b>Wm A. Feiser</b>		ADDRESS <b>205 Carlisle St Hanover, Pa</b>	
--	--	---	--	---	--	---	--

N 501.2

0058M

1860

MEDICAL CERTIFICATION

Name of Deceased		Date of Death	
Place of Birth		Place of Death	
Cause of Death		Manner of Death	
Occupation		Residence	
Signature of Physician		Signature of Coroner	
Signature of Registrar		Signature of Witness	

AB-142371

b-630

50 8704

BALTIMORE CITY HEALTH DEPARTMENT

50 8704

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Benjamin Baird

2. DATE  
OF  
DEATH

10-10-1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTIONBaltimore City Hospitals  
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

a. STATE

b. COUNTY

Maryland

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

d. STREET ADDRESS (If rural, give location)

1906 E. Fayette St. 6-04

Length of stay in Baltimore

8yrs

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

WELDER

10b. KIND OF BUSINESS OR INDUSTRY

STEEL MILL

13. FATHER'S NAME

Henry Baird

8. DATE OF BIRTH

Dec. 15-1914

9. AGE (In years last birthday)

35

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Cora Jenkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Records: Baltimore City Hospitals  
4940 Eastern Ave.

18. 002X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis

DUE TO

Several months History

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10-9-1950, to 10-10-1950 that I last saw the deceased alive on 10-10-1950, and that death occurred at 5:15AM from the causes and on the date stated above.

23a. SIGNATURE

J. H. Rogers

M. D.

23b. ADDRESS  
Baltimore City Hospitals  
4940 Eastern Ave.

23c. DATE SIGNED

10-10-1950

24a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24b. DATE

10-13-50

24c. NAME OF CEMETERY OR CREMATORY

Edge Hill

24d. LOCATION (City, town, or county)

Nanticoke, Penna.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 10 1950

Washington Williams, M.D.

Wm. J. Dickner, Genl. Balto., Md.

685-3A

0136

MEDICAL CERTIFICATION

where necessary, please write the cause of death and the cause of death.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**CECILE KINGSLEY HARDEN**

2. DATE  
OF  
DEATH

**10-10-50**

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF (If not in hospital or institution, give street address or location)

**UNION MEMORIAL HOSPITAL**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **MARYLAND**

B. COUNTY

**Baltimore**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**OWING MILLS**

d. STREET ADDRESS (If rural, give location)

**NONE**

Length of stay in Baltimore

**LIFE TIME 9**

5. SEX

**Female**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED,

**WIDOWED, DIVORCED (Specify)**

**MARRIED**

8. DATE OF BIRTH

**FEB 17, 18 93**

9. AGE (In years last birthday)

**57**

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Housewife**

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**BALTO. MD.**

12. CITIZEN OF WHAT COUNTRY?

**USA**

13. FATHER'S NAME

**JOSEPH KINGSLEY**

14. MOTHER'S MAIDEN NAME

**ELIZABETH**

**BETCH**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**Key F. Harden Owing Mills**

18. **193X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

**Milline cerebellar Tumor**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **9/14/50**, 19**50**, to **10/10/50**, 19**50**, that I last saw the deceased alive on **10/10/50**, 19**50**, and that death occurred at **7:35 A.m.**, from the causes and on the date stated above.

23a. SIGNATURE

**Richard Beach**

M. D.

23b. ADDRESS

**Union Memorial Hosp.**

23c. DATE SIGNED

**10/10/50**

24a. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24b. DATE

**Oct 13/50**

24c. NAME OF CEMETERY OR CREMATORY

**All Saints**

24d. LOCATION (City, town, or county) (State)

**Rustertown Balto City**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Thurston Williams, M.D.**

25. FUNERAL DIRECTOR

ADDRESS

**J. F. Elmer Sons Rustertown**

**OCT 10 1950**

VS 150

**54B**

MEDICAL CERTIFICATION

"malignant brain tumor, primary site."

See Document File 50-8705

10-18-50

SS.



S 140  
50 8706

50 8706

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

CORDELIA SEIBEL

2. DATE  
OF  
DEATH

10/9/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2802 MONTBELLO AVE

C. Length of stay in Baltimore

50

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

A. STATE

MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2802 MONTBELLO

27-02

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

1876

9. AGE (In years last birthday)

74

If Under 1 Year

Months

Days

If Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SEAMSTRESS

10B. KIND OF BUSINESS OR INDUSTRY

SEWING

11. BIRTHPLACE (State or foreign country)

BALTIMORE Co. MD

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

KOLBE

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL SECURITY NO.

—

17. INFORMANT

ADDRESS

ANNA D. WIGNER, 2802 MONTBELLO

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Hypertensive Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Cerebral Hemorrhage

2-3 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/5, 1950, to 10/9, 1950, that I last saw the deceased alive on 10/9, 1950, and that death occurred at 8 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

5103 MacJannet Rd

10/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

BURIAL

10/11/50

David Ridge

Pikesville, Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

690 4G

0932

MEDICAL CERTIFICATION

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Andrew Parr*

2. DATE  
OF  
DEATH

*Oct 10, 1958*

3. PLACE OF DEATH

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

*JOHNS HOPKINS HOSPITAL*

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*Rutherford Heights*

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Richard Parr*

14. MOTHER'S MAIDEN NAME

*Verotney Brubaker*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. *754.6*

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

*Congenital heart disease.*

*Congenital*

DUE TO

*(transposition great vessels).*

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

*10-10-50*

19B. MAJOR FINDINGS OF OPERATION

*Cong. heart disease, transposition great vessels*

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *10-10-50*, 1950 to *10-10-*, 1950, that I last saw the deceased alive on *10-10-*, 1950 and that death occurred at *2:50 P.* m., from the causes and on the date stated above.

23A. SIGNATURE

*AS Morrow*

M. D.

23B. ADDRESS

*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED

*10-10-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*Oct 10/50*

24C. NAME OF CEMETERY OR CREMATORY

*Hummelstown Pa. Hummelstown Pa.*

24D. LOCATION (City, town, or county)

*Hummelstown Pa.*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

*OCT 11 1950*

REGISTRAR'S SIGNATURE

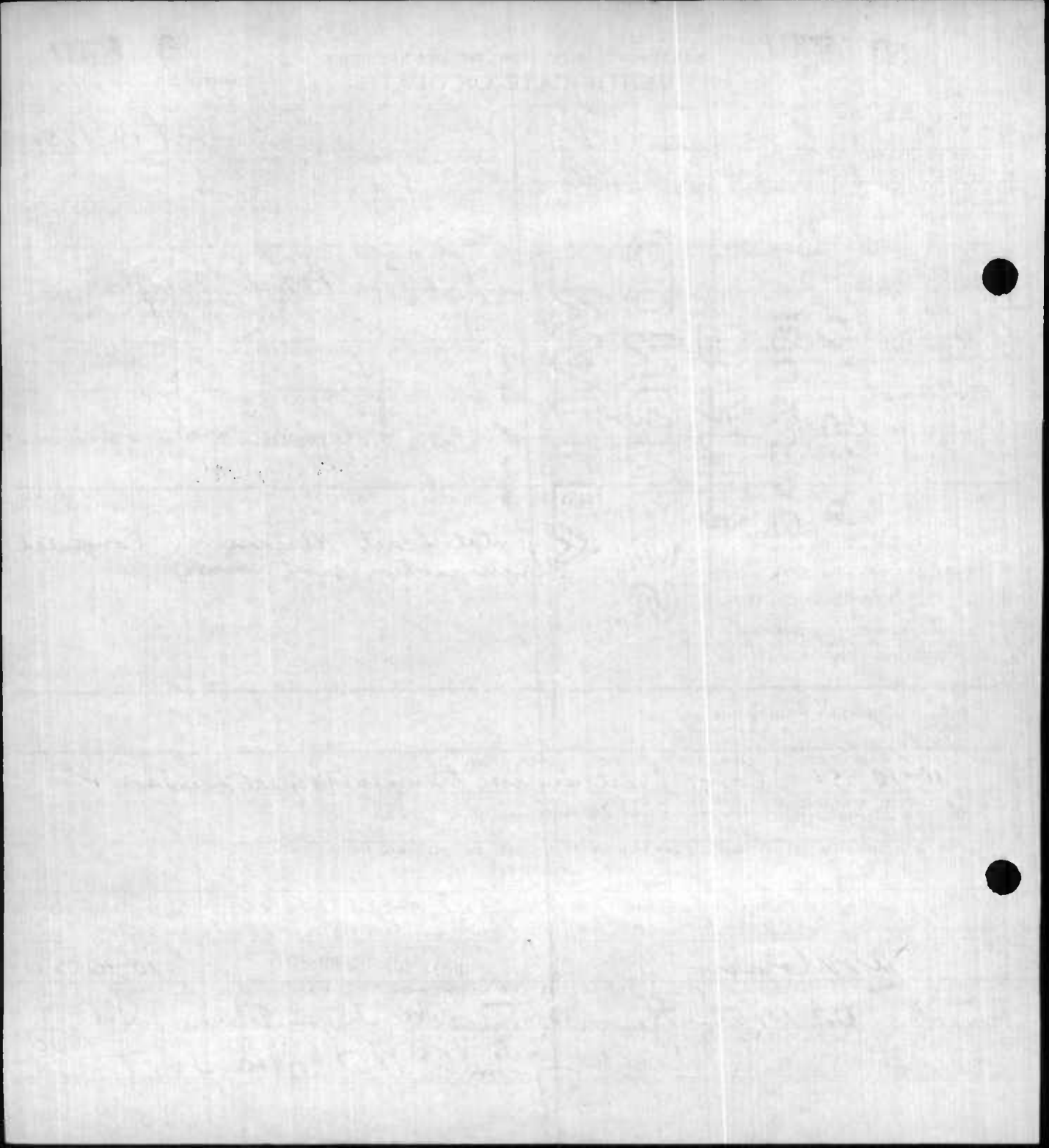
*Wilmington Williams, M.D.*

25. FUNERAL DIRECTOR

*John O. Mitchell & Sons Easton Pa.*

ADDRESS

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. 7. R.

1. NAME OF DECEASED  
(Type or Print) Baby Boy Johnson

2. DATE OF DEATH October 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Harriet Lane Home

4. USUAL RESIDENCE (Where deceased lived. If institution - residence before admission)  
A. STATE md. B. COUNTY Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bundalk 5300

Length of stay in Baltimore

Yrs.  
Mos.  
Days

O. STREET ADDRESS (If rural, give location) 205 Sallers Point Rd.

5. SEX male

6. COLOR OR RACE colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single

8. DATE OF BIRTH 10-1-50

9. AGE (in years last birthday) 8 If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME P.

14. MOTHER'S MAIDEN NAME Adele Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

18. 776x

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

OR TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

OR TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10-1, 1950, to 10-1, 1950, that I last saw the deceased alive on 10-1, 1950 and that death occurred at 8 P.m., from the causes and on the date stated above.

23A. SIGNATURE Henry M. Seidel

M. O.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED 10/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY Destroyed By Hospital

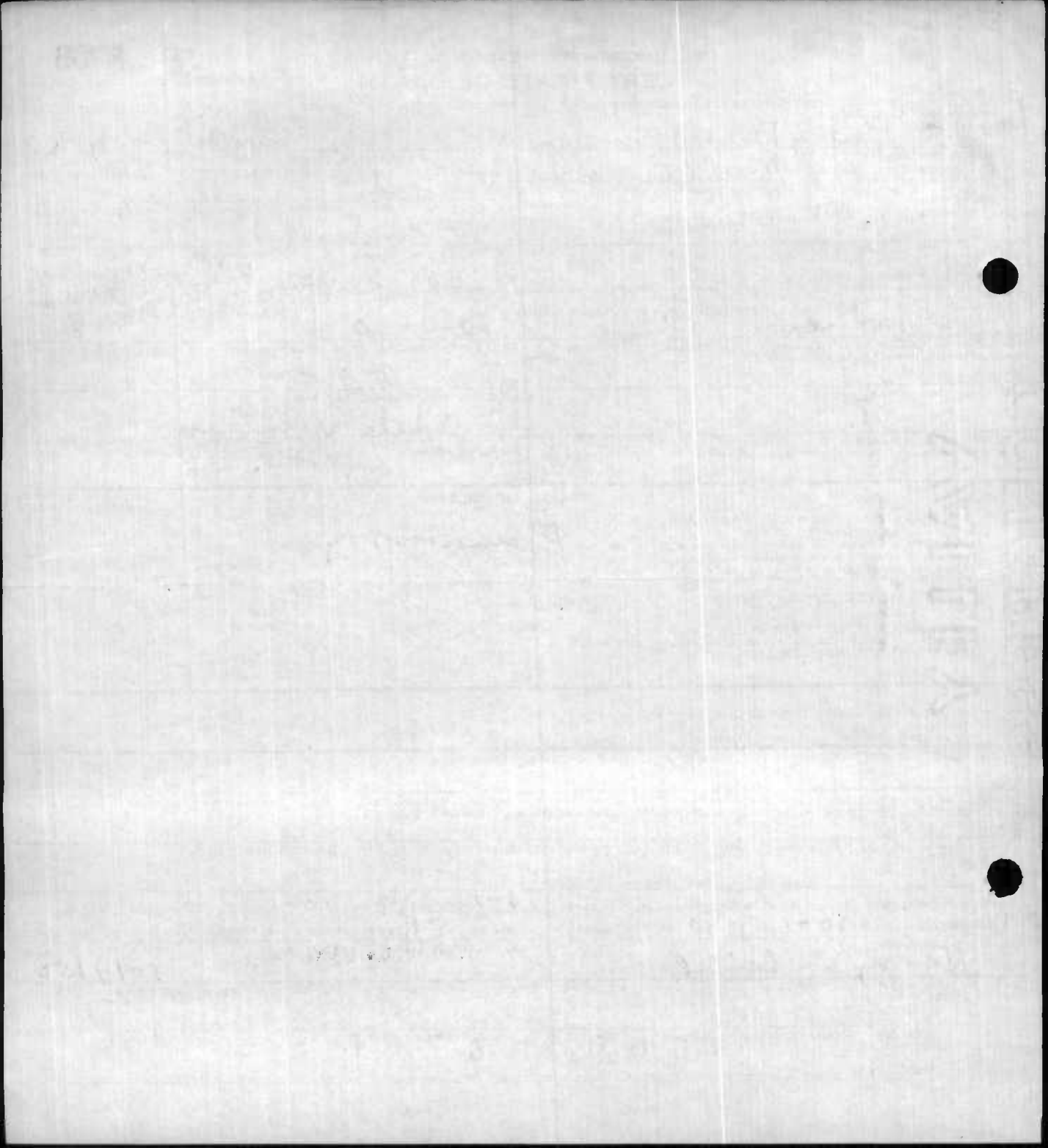
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE Wilmington, Md.

25. FUNERAL DIRECTOR

ADDRESS





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Mike (Michael) SHUMSKY</b>		2. DATE OF DEATH <b>Oct. 8, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>Lutheran Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 15-09</b>	
D. STREET ADDRESS (If rural, give location) <b>4012 Batemen St.</b>		E. LENGTH OF STAY IN BALTIMORE <b>40 yrs</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>?</b>
9. AGE (In years last birthday) <b>59</b>		10. UNDER 1 Year Months: _____ Days: _____	11. UNDER 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>rocket maker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Choth Mfg.</b>	
11. BIRTHPLACE (State or foreign country) <b>L.I.H.</b>		12. CITIZEN OF WHAT COUNTRY? <b>—</b>	
13. FATHER'S NAME <b>? Shumsky</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-24-0623</b>	
17. INFORMANT <b>Virginia Shumsky</b>		ADDRESS <b>4012 Batemen St.</b>	

18. <b>E903.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Fracture of skull and intracranial hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
(B) DUE TO		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>About yard of home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>4014 Batemen St.</b>	
21D. TIME (Month) (Day) (Year) (Hour) (Minute) <b>abt. Oct. 7, 1950 5 p. m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell striking head against stone building</b>	
22. I certify that I took charge of the remains described above, held an <b>Partial Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>Stanley H. Dunlavy</b>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>Oct. 9, 1950</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 12-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Landon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Fredrick Ave BALTO Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>Oct 11 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Joseph J. Banskas Jr.</b>		ADDRESS <b>602 Wash. Bldg</b>	

VS 151 **N803.2** **690 4G** **186a**

MEDICAL CERTIFICATION

Please print the cause of death clearly and legibly.

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Time of death

8. Cause of death

9. Place of death

10. Signature of doctor

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of medical officer

15. Signature of health officer

16. Signature of coroner

17. Signature of jury

18. Signature of magistrate

19. Signature of judge

20. Signature of clerk

21. Signature of secretary

22. Signature of treasurer

23. Signature of auditor

24. Signature of assessor

25. Signature of collector

26. Signature of inspector

27. Signature of surveyor

28. Signature of engineer

29. Signature of architect

30. Signature of painter

31. Signature of carpenter

32. Signature of mason

33. Signature of bricklayer

34. Signature of joiner

35. Signature of cooper

36. Signature of blacksmith

37. Signature of farrier

38. Signature of wheelwright

39. Signature of cooper

40. Signature of cooper

41. Signature of cooper

42. Signature of cooper

43. Signature of cooper

44. Signature of cooper

45. Signature of cooper

46. Signature of cooper

47. Signature of cooper

48. Signature of cooper

49. Signature of cooper

50. Signature of cooper

51. Signature of cooper

52. Signature of cooper

53. Signature of cooper

54. Signature of cooper

55. Signature of cooper

513 50 8710

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 8710

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Richard Glenn Hampt

2. DATE  
OF  
DEATH

Oct. 10, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

UNION MEMORIAL HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

MARYLAND.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

27-14

D. STREET ADDRESS (If rural, give location)

4540 KESWICK ROAD

Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

SEX

MALE

WHITE

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

SINGLE

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SCHOOL

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

RUSSELL G. HAMPT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

DEC 8, 1939

9. AGE (In years last birthday)

10

If Under 1 Year Months Days

If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

MARYLAND.

12. CITIZEN OF WHAT COUNTRY?

U. S.

14. MOTHER'S MAIDEN NAME

MARGARET A. CORLISS

17. INFORMANT

ADDRESS

RUSSELL G. HAMPT-4540 KESWICK RD.

18.

474X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Septicemia

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Cause Undetermined

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

(over)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from Oct. 10, 1950, to Oct. 10, 1950, that I last saw the deceased alive on Oct. 10, 1950, and that death occurred at 10:00 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Richard Beason

23B. ADDRESS

M. D.

Union Memorial Hospital

23C. DATE SIGNED

10/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

Oct 13/50

24C. NAME OF CEMETERY OR CREMATORY

St. Mary's Hospital

24D. LOCATION (City, town, or county)

Roland Ave Balto Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

E. Donovan 3818 Roland Ave

ADDRESS

OCT 11 1950

VS 150

106c

When the autopsy  
results become available,  
please advise probable  
cause underlying septicemia?

See Document File 50-8710 for full autopsy findings

In part " 1. "Acute tracheitis and mediastinitis," etc

1/8/1951 - E. Steman

LC 133564

50 8711

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8711

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Richard Joyce</b>			2. DATE OF DEATH <b>Oct. 9, 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
D. STREET ADDRESS (If rural, give location) <b>801 S. Bond St. 347 Spring CT.</b>					
5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>			8. DATE OF BIRTH <b>Nov 7, 1907</b>		
9. AGE (In years last birthday) <b>42</b>			10. CITIZEN OF WHAT COUNTRY? <b>CT.</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>CT.</b>		
13. FATHER'S NAME <b>Frank Joyce</b>			14. MOTHER'S MAIDEN NAME <b>Bertha Shepphard</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>314-18-5811</b>		
17. INFORMANT <b>Records- Baltimore City Hospitals</b>			ADDRESS <b>4940 Eastern Ave.</b>		

18. <b>002X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Tuberculosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 Year</b>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>None</b>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>None</b>		

19A. DATE OF OPERATION <b>Oct. 9, 1950</b>		19B. MAJOR FINDINGS OF OPERATION <b>None</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Home</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>Oct. 9, 1950, 2:30 AM</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>None</b>	

22. I hereby certify that I attended the deceased from **Nov. 18, 1949** to **Oct. 9, 1950** that I last saw the deceased alive on **Oct. 9, 1950** and that death occurred at **2:30 AM**, from the causes and on the date stated above.

23A. SIGNATURE <b>W. S. Rogers</b>		23B. ADDRESS <b>4940 Eastern Avenue</b>		23C. DATE SIGNED <b>10-9-50</b>	
---------------------------------------	--	--	--	------------------------------------	--

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 11 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>	
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24D. LOCATION (City, town, or county) (State) <b>Balt. Md.</b>		25. FUNERAL DIRECTOR <b>Frank J. Keller</b>		ADDRESS <b>322 S. High St.</b>	
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OCT 11 1950

OCT 11 1950

583 4F

013 6

1170

1170

1170-81-011

General - Oct. 21 1950  
J. Edgar Hoover  
U. S. Dept. of Justice  
Washington, D. C.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Samuel Green</i>		2. DATE OF DEATH <i>10-10-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>E. C. A.</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>15-02</i>	
Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <i>1807 Presbury St.</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M</i>	8. DATE OF BIRTH <i>-1866</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>84</i>
11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Not Known</i>		14. MOTHER'S MAIDEN NAME <i>Not Known</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Samuel Weintraub - 578 N. Gay St.</i>	

18. *E 902.0*

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Fracture of Skull*

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Cerebral contusion*

DUE TO

(C) *Possible Subdural hematoma.*

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY  
*Dr. William G. Helfrich*

19A. DATE OF OPERATION *0* 19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  
*accident*

21B. PLACE OF INJURY (e. g., in or about home, farm, school, etc., office, etc.)  
*1807 Presbury St.*

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
*1807 Presbury St.*

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  
*Oct 8 1950 11 P. M.*

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?  
*Fell down from stairway*

22. I hereby certify that I attended the deceased from *10-9-50*, 19\_\_, to *10-10-*, 1950, that I last saw the deceased alive on *10-9-*, 19\_\_, and that death occurred at *11:45* m., from the causes and on the date stated above.

23A. SIGNATURE *Luan Muehly* M. D. 23B. ADDRESS *2025 Fayette St.* 23C. DATE SIGNED *10-10-50*

24A. BURIAL, CREMATION, REMOVAL (Specify) *burial* 24B. DATE *10-11-50* 24C. NAME OF CEMETERY OR CREMATORY *Rosedale* 24D. LOCATION (City, town, or county) (State) *Baltimore Md*

DATE RECEIVED BY LOCAL REGISTRAR *Oct 11 1950* REGISTRAR'S SIGNATURE *William Williams* 25. FUNERAL DIRECTOR *Jack Lewin* ADDRESS *2100 Canton Pl*

VS 150

*N 803.0*

*186a*

MEDICAL CERTIFICATION

This certificate is to be filled out by a physician, nurse, or other qualified person, and is to be signed by the physician, nurse, or other qualified person, and is to be filed in the office of the health department.

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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WASHINGTON, D. C.

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WASHINGTON, D. C.

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

35550

8713

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Simon D. Goodman*

2. DATE  
OF  
DEATH

*Oct 10, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

*3333 Alto Road*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

*West Virginia*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Farmington*

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

*7* Days

SEX

*M*

6. COLOR OR RACE

*W*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Single*

8. DATE OF BIRTH

9. AGE (In years last birthday)

*66*

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Secretary*

10B. KIND OF BUSINESS OR INDUSTRY

*Tuberculosis Assn*

11. BIRTHPLACE (State or foreign country)

*Russia*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Moses*

14. MOTHER'S MAIDEN NAME

*Hattie*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

*Ralph Chor - 3402 Forest Park Ave*

18. *420.1*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

*Coronary Occlusion*

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*William J. Helbuch*

M.D.

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

23C. DATE SIGNED

*10-11-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

*Burial*

*10-12-50*

*United Hebrew*

*Balto, Md*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*OCT 11 1950*

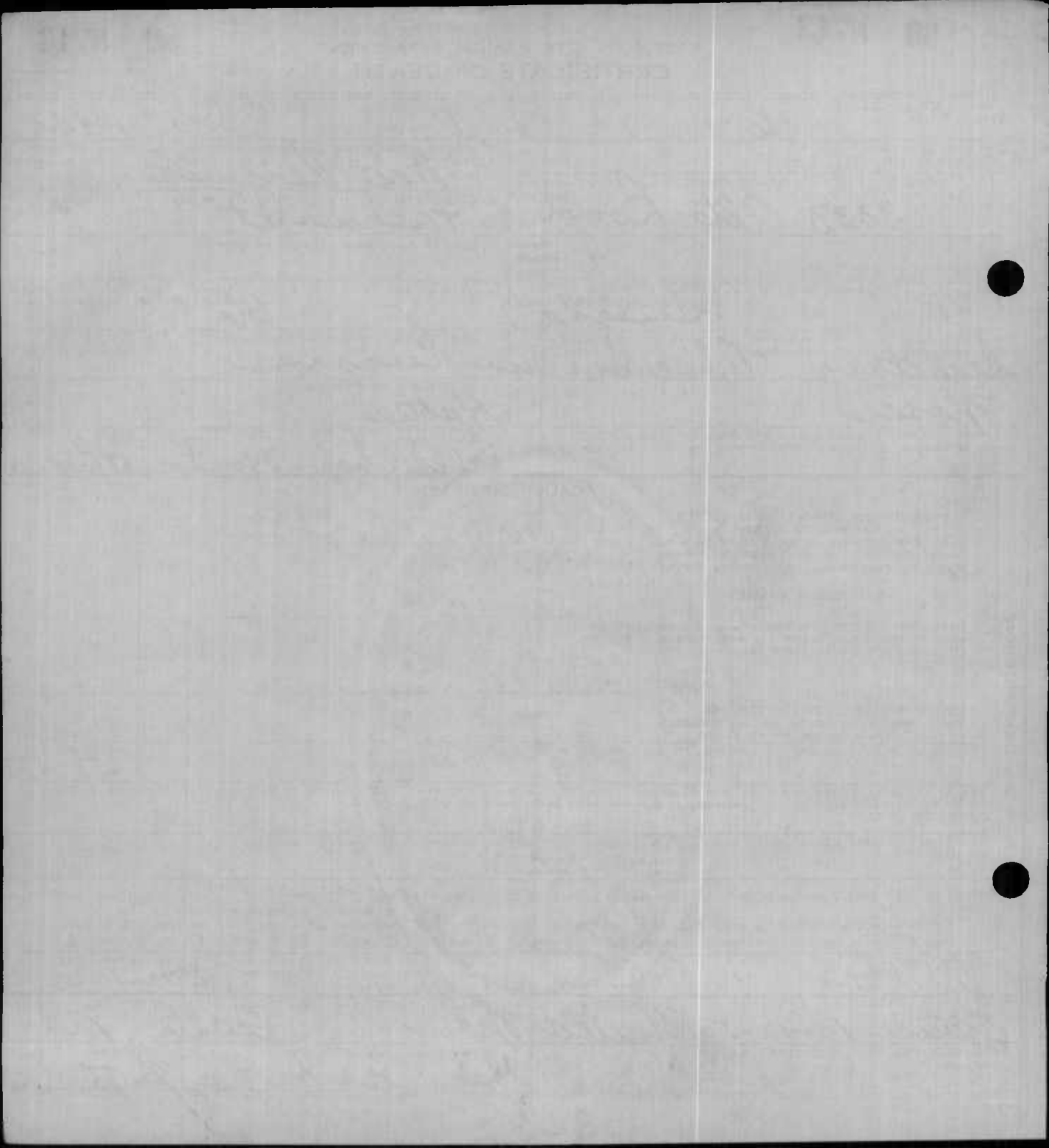
*William J. Helbuch*

*Jack Lewis 2100 Putnam Pl*

VS 151

35082

094a



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>George Keefer</i>		2. DATE OF DEATH <i>Oct 10, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Med / Oct 6</i>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Wandall 22</i>	
D. STREET ADDRESS (If rural, give location) <i>1204 12 5300</i>		E. LENGTH OF stay in Baltimore Yrs. _____ Mos. _____ Days _____	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Separated</i>	8. DATE OF BIRTH <i>8-3-1913</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>STEEL MILL</i>	9. AGE (in years last birthday) <i>37</i>
11. BIRTHPLACE (State or foreign country) <i>Pa</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>William Keefer</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Pritchett</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>		ADDRESS	

18. <i>434.3</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) <i>Chronic Cor Pulmonale</i> DUE TO (B) <i>Pulmonary Emphysema</i> DUE TO (C) <i>and Fibrosis</i>	INTERVAL BETWEEN ONSET AND DEATH <i>5-6 yrs</i> ?
---	---	---

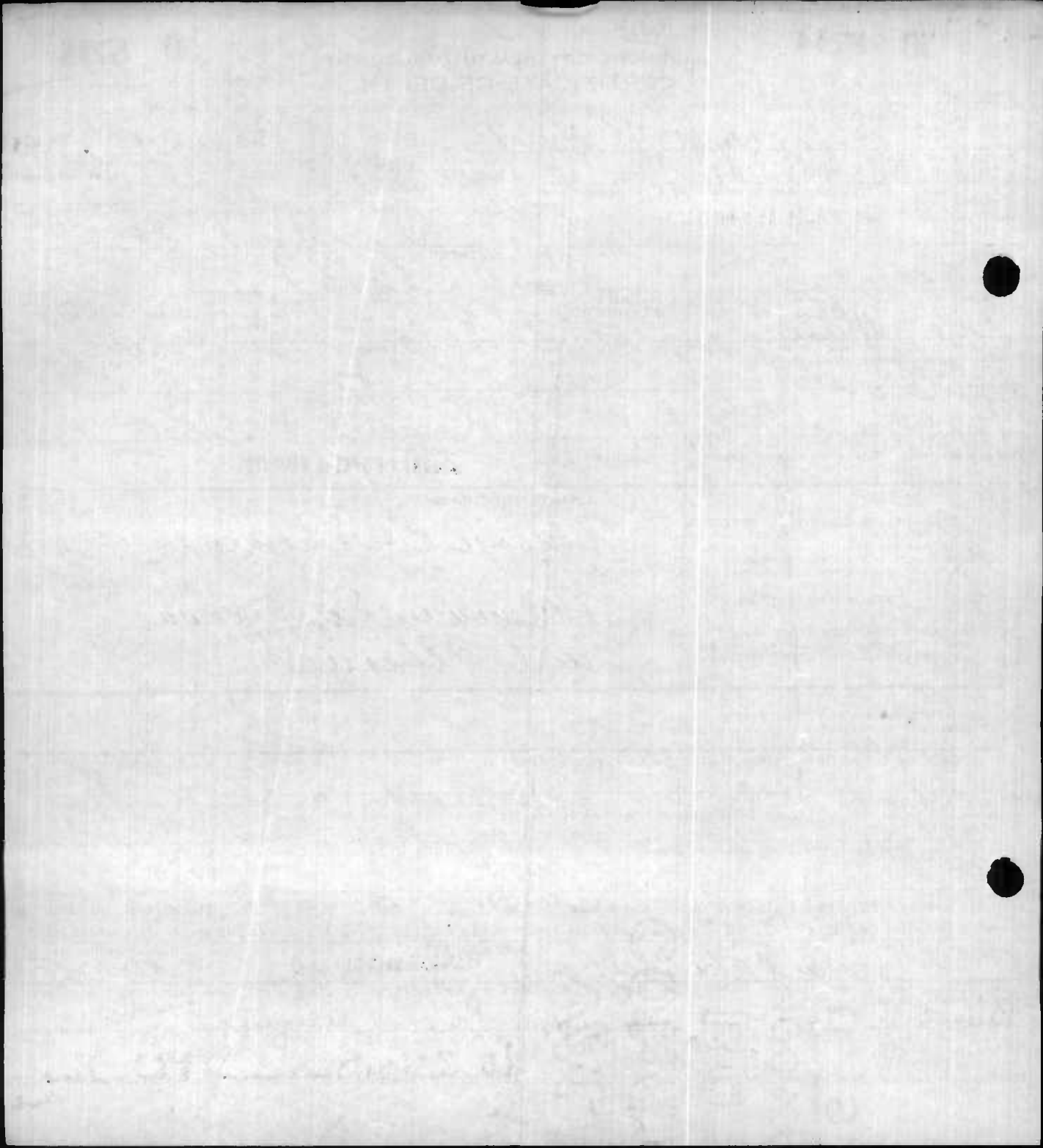
19A. DATE OF OPERATION <i>2</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>9-21-</i> , 19 <i>50</i> , to <i>10-10-</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>10-10-</i> , 19 <i>50</i> and that death occurred at <i>11:30</i> a.m., from the causes and on the date stated above.				
23A. SIGNATURE <i>David Lukens</i>		23B. ADDRESS <i>1413 N. MICHIGAN ST. BALTIMORE, MD.</i>		23C. DATE SIGNED <i>10-10-50</i>

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>10-13-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Oakquippa Pa.</i>	24D. LOCATION (City, town, or county) (State) <i>Oakquippa Pa.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 11 1950</i>		REGISTRAR'S SIGNATURE <i>Washington Williams</i>	25. FUNERAL DIRECTOR <i>Edward J. Dineen</i>

*970 3A*

*095C*

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**FLETCHER, JOSEPH**

2. DATE  
OF  
DEATH

**9 OCT. 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
**LUTHERAN HOSP. OF MD.**

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE **MD.** B. COUNTY \_\_\_\_\_

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)  
**BALTIMORE 24-01**

D. STREET ADDRESS (If rural, give location)  
**1457 ANDRE ST.**

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

**M**

6. COLOR OR RACE

**W**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**S**

8. DATE OF BIRTH

**MAY 14 1900**

9. AGE (In years last birthday)

**50**

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**LABORER - HOVAK**

10B. KIND OF BUSINESS OR INDUSTRY  
**ODD JOBS**

11. BIRTHPLACE (State or foreign country)  
**VA.**

12. CITIZEN OF WHAT COUNTRY?  
**US**

13. FATHER'S NAME

**EDWARD FLETCHER**

14. MOTHER'S MAIDEN NAME

**MARY EAVENS**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
**NO**

16. SOCIAL SECURITY NO.  
**212-14-0104**

17. INFORMANT

ADDRESS

**JAMES FLETCHER 1457 ANDRE ST.**

18. **540.1**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**(A) GASTRO INTESTINAL BLEEDING**  
DUE TO

**2 WRS.**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
**(B) GASTRIC ULCER**  
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
**PERFORATED GASTRIC ULCER**

19A. DATE OF OPERATION

**22 SEPT. 1**

19B. MAJOR FINDINGS OF OPERATION

**PERFORATED GASTRIC ULCER**

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **22 SEPT. 1950**, to **9 OCT. 1950**, that I last saw the deceased alive on **9 OCT. 1950**, and that death occurred at **2:30 P. M.**, from the causes and on the date stated above.

23A. SIGNATURE

**James D. O'Hara, M.D.**

23B. ADDRESS

**Luthan 1457**

23C. DATE SIGNED

**9 OCT. 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**OCT 11 1950**

**Washington**

**8 Mr. J. Dill 1501 E. Fort Ave.**

MAY 14 50

James + Ernest Fletcher

520  
50 8716ROBERT AMES  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8716

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Ames Robert

2. DATE  
OF  
DEATH

10/7/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street address or location)

Provident Hospital

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

January 4 1900

9. AGE (In years  
last birthday)

50

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Egg packer

10B. KIND OF BUSINESS OR  
INDUSTRY

Creamery Plant

11. BIRTHPLACE (State or foreign country)

Balt., Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Georges Ames

14. MOTHER'S MAIDEN NAME

Luella Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

16. SOCIAL  
SECURITY NO.  
(If yes, give war or dates of service)

No

218-07-5249

17. INFORMANT

ADDRESS

Louise Ames (W) 409 Myrtle Ave

18. 002X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Uremia

DUE TO

10-7-50

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Pulmonary Tuberculosis

DUE TO

10-7-50

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Osteomyelitis of right femur

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-3-1940 to 10-7-1950, that I last saw the  
deceased alive on 10-7-1950, and that death occurred at 8:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Aristomene Nicolas

M. D.

23B. ADDRESS

Provident Hospital

23C. DATE SIGNED

10/8/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

10/12/50

24C. NAME OF CEMETERY OR CREMATORY

Mountain Cemetery

24D. LOCATION (City, town, or county)

Kingsville, Hartford County

(State)  
MDOATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Chas. J. Jester

ADDRESS

512 N. Carrollton Ave

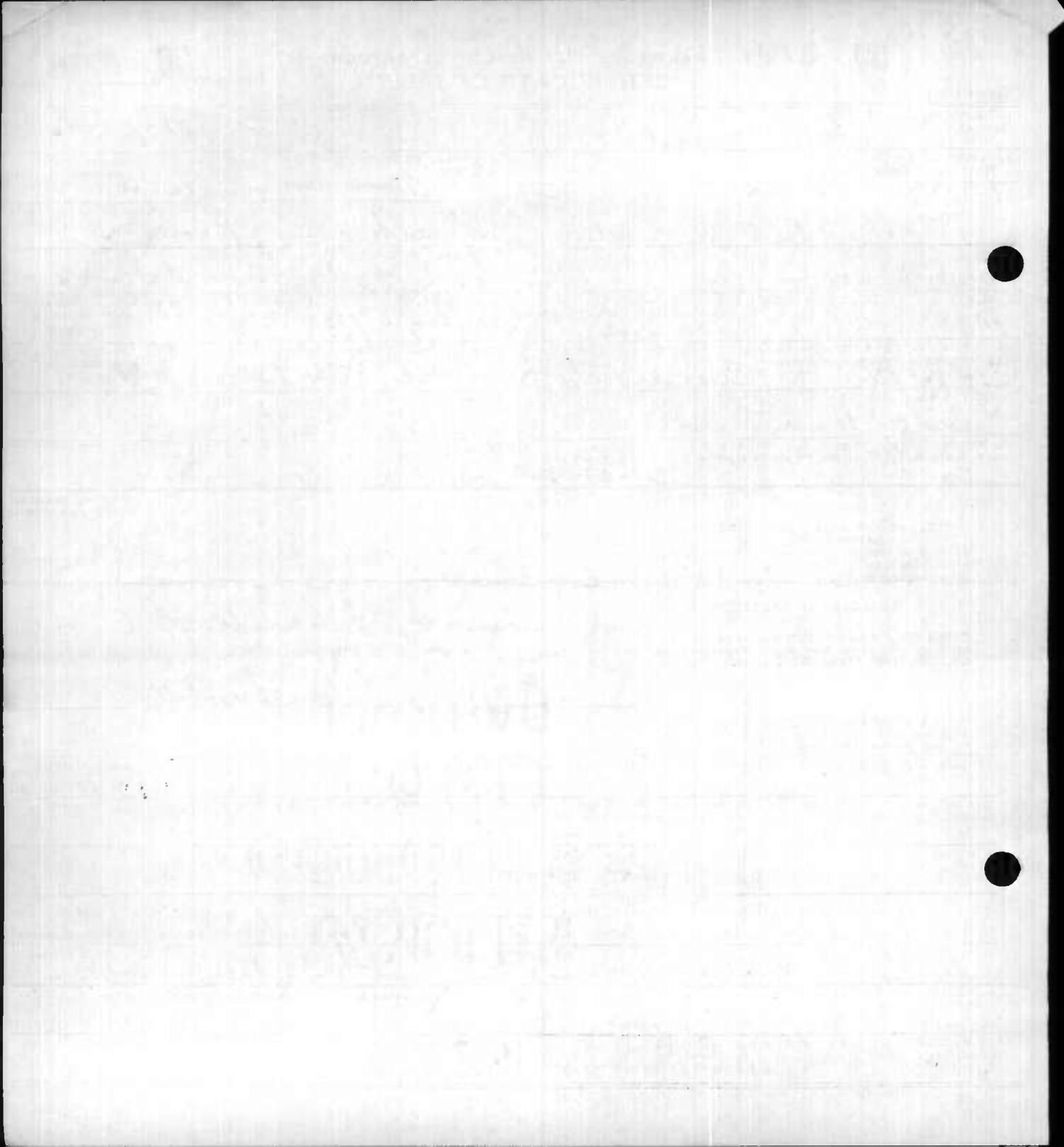
OCT 11 1950

VS 150

69063

0136

MEDICAL CERTIFICATION



BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE THOMAS PETTUS

2. DATE  
OF  
DEATH

October 9, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR US Marine Hospital  
INSTITUTION Wyman Pk. Drive & 31st St.4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE Md.  
B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 25-32

D. STREET ADDRESS (If rural, give location)

2834 Winwood Court

E. Length of stay in Baltimore ?

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

col

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

2/5/24

9. AGE (In years  
last birthday)

26

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR  
INDUSTRY

Veh School

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

George Pettus

14. MOTHER'S MAIDEN NAME

Virginia ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

Yes

WW 2

16. SOCIAL  
SECURITY NO.

Yes- ?

17. INFORMANT

ADDRESS

Records- US Marine Hospital, Balto, Md.

18. 201X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHOver  
4 yrs.DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Hodgkin's disease with involvement  
of liver, spleen, vertebrae

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from July 24, 1950, to Oct. 9, 1950, that I last saw the deceased alive on Oct. 9, 1950, and that death occurred at 5:20P m., from the causes and on the date stated above.

23A. SIGNATURE  
John L. Wilson, Medical Director

M. D.

23B. ADDRESS  
US Marine Hospital, Balto, Md.23C. DATE SIGNED  
10/10/5024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Funeral Home

OCT 11 1950

VS 150

0446

corrected as to spelling important. Registrars: please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

STATE OF TEXAS  
COUNTY OF DALLAS

IN SENATE,  
January 1, 1900.

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR  
ENDING DECEMBER 31, 1899.

ALBINO C. CARR,  
COMMISSIONER.

PRINTED BY  
THE TEXAS PRINTING CO.,  
DALLAS, TEXAS.

1900.

THE TEXAS PRINTING CO.,  
DALLAS, TEXAS.

1900.

THE TEXAS PRINTING CO.,  
DALLAS, TEXAS.

1900.



50 8718

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8718

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN F. APPELL

2. DATE  
OF  
DEATH

OCT. 9, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland BALTO, MD

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION1500 E. 28<sup>th</sup> St.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BALTIMORE 9-07D. STREET ADDRESS (If rural, give location)  
1500 E. 28<sup>th</sup> ST.

Length of stay in Baltimore

LIFETIME

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CONTRACTOR

10B. KIND OF BUSINESS OR INDUSTRY

OWN BUSINESS

13. FATHER'S NAME

GEORGE APPELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, do or unknown) (If yes, give war or dates of service)

NO

NO

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

JUNE 17, 1894

9. AGE (In years last birthday)

56

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

BALTO. MD

12. CITIZEN OF WHAT COUNTRY?

U. S.

14. MOTHER'S MAIDEN NAME

MARY F. HOFNAGLE

17. INFORMANT WIFE ADDRESS

MRS. MARY E. APPELL (SAME)

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 3, 1950, to Oct 9<sup>th</sup>, 1950, that I last saw the deceased alive on Oct 7, 1950, and that death occurred at 6 A. m., from the causes and on the date stated above.

23A. SIGNATURE

William H. Fusting

M. D.

23B. ADDRESS

11 E. Chase St.

23C. DATE SIGNED

10-10-50

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10-13-1950

24C. NAME OF CEMETERY OR CREMATORY

NEW CATHEDRAL

24D. LOCATION (City, town, or county) (State)

OLD FREDERICK RD.

DATE RECEIVED BY  
LOCAL REGISTRAR

OCT 11 1950

REGISTRAR'S SIGNATURE

Huntington Williams, MD

25. FUNERAL DIRECTOR

J. Walter Euklein

ADDRESS

2343 HARFORD RD.

NO. 10

CERTIFICATE OF TITLE

NO. 10

1910

JOHN F. BROWN

MATHEW

JOHN F. BROWN

1910

1910

JOHN F. BROWN

JOHN F. BROWN

JOHN F. BROWN

JOHN F. BROWN

JOHN F. BROWN

JOHN F. BROWN

JOHN F. BROWN

JOHN F. BROWN

JOHN F. BROWN

JOHN F. BROWN

JOHN F. BROWN

JOHN F. BROWN

720  
B-142248

50 8719

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

420796

1. NAME OF DECEASED  
(Type or Print)

Robert Carson Volz

2. DATE  
OF  
DEATH

10-8-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

8. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Rural- Essex

5300

D. STREET ADDRESS (If rural, give location)

1621 Doolittle Rd-Apt.G. zone 21

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

March 13- 1945

9. AGE (In years  
last birthday)

5

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland, Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Volz

14. MOTHER'S MAIDEN NAME

Eleen(Ellen) Cassell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT Baltimore City Hospitals  
Records: 4940 Eastern Ave.

18. 080.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Bulbar Poliomyelitis

DUE TO

5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from 10-5-1950 to 10-8-1950, that I last saw the  
deceased alive on 10-3-1950 and that death occurred at 1.20AM, from the causes and on the date stated above.

23A. SIGNATURE

*J. S. Rogers* M. D.

23B. ADDRESS

Baltimore City Hospitals  
4940 Eastern Ave.

23C. DATE SIGNED

10-8-1950

24A. BURIAL, CREMA-  
TION REMOVAL (Specify)

24B. DATE

Oct. 11, 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery North Ave & Rose Street

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*W. H. Williams, M.D.*

25. FUNERAL DIRECTOR

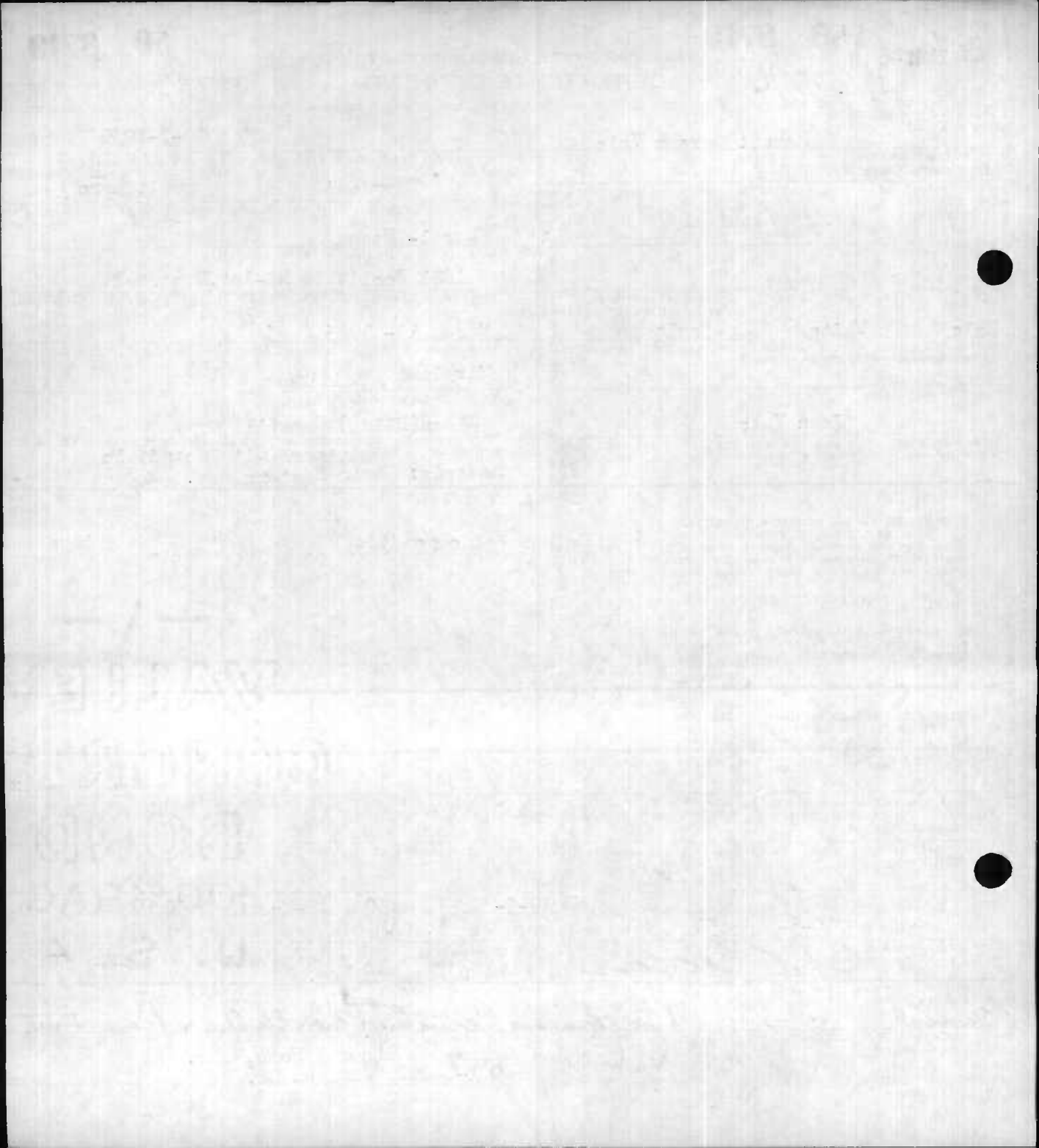
Schironek Funeral Home, Inc.  
2601 E. Madison St.

ADDRESS

OCT 11 1950

036.0

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Morris Horwitz*

2. DATE  
OF  
DEATH

*10/10/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived if institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*4501 Park Hgts Ave*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore Md*

D. STREET ADDRESS (If rural, give location)

*4501 Park Hgts Ave*

Length of stay in Baltimore

*50 Yrs*

5. SEX

*M*

6. COLOR OR RACE

*W*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*Married*

8. DATE OF BIRTH

*1898 June 17*

9. AGE (in years last birthday)

*52*

4 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Chauffeur*

10B. KIND OF BUSINESS OR INDUSTRY

*Taxi-cab (Fleetway)*

11. BIRTHPLACE (State or foreign country)

*Russia*

12. CITIZEN OF WHAT COUNTRY?  
*USA.*

13. FATHER'S NAME

*late Aaron Horwitz*

14. MOTHER'S MAIDEN NAME

*Ella Myerson*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.  
*219-03-7743*

17. INFORMANT

ADDRESS

*Mrs. Pearl Horwitz-4501 Park Heights Ave.*

18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*Cerebral Thrombosis*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*[Signature]*

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED *10/10/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)  
*Burial*

24B. DATE

*10-12-50*

24C. NAME OF CEMETERY OR CREMATORY

*Ohel Yakov Congregation*

24D. LOCATION (City, town, or county)

*Baltimore, Maryland*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*[Signature]*

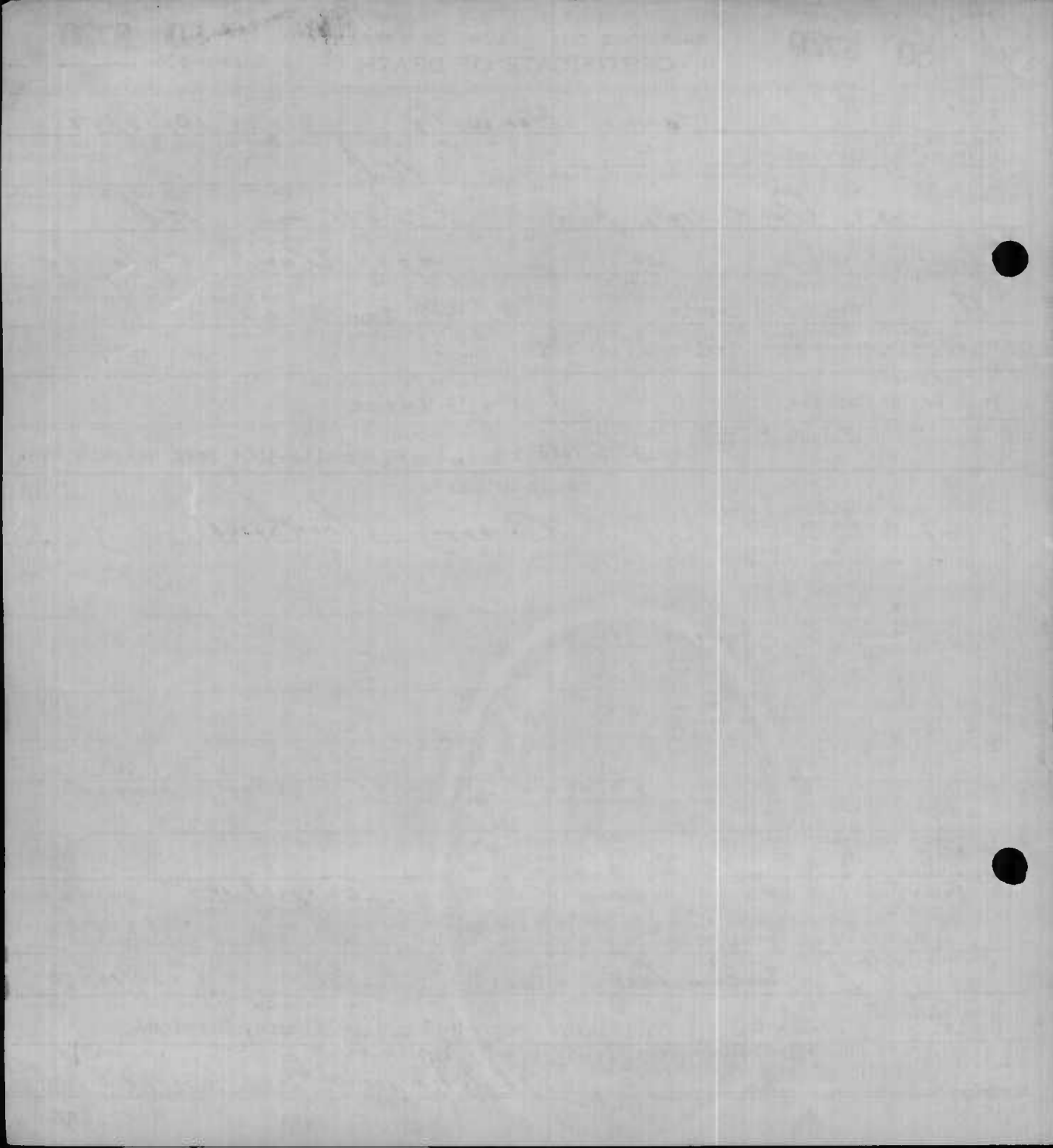
25. FUNERAL DIRECTOR

ADDRESS

*Sol. Helinson & Bros. 1124-26 W. North*

MEDICAL CERTIFICATION

Correct age is extremely important. If unsure, please write the cause of death clearly and legibly.





# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 8721

BIRTH NO. 520 50 8721

1. NAME OF DECEASED (Type or Print) <b>THEODORE JONES</b>		2. DATE OF DEATH <b>October 9, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>17-01</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>593 Orchard Street</b>		E. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>2/4/</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Contracting Co</b>	9. AGE (In years last birthday) <b>32</b> If Under 1 Year: Months _____ Days _____ If Under 24 Hours: Hours _____ Min. _____
13. FATHER'S NAME <b>Joseph Jones</b>		11. BIRTHPLACE (State or foreign country) <b>Warren Co., S.C.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO. <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>Laura E. Foster</b>	
17. INFORMANT <b>Henderson, N.C.</b>		ADDRESS <b>Garnes-Williams Funeral Home</b>	

18. <b>241 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Status asthmaticus</b> DUE TO (A) _____ ANTECEDENT CAUSES DUE TO (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH
---	----------------------------------

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>William V. Smith</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>October 10, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>10/12/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Henderson</b>	
24D. LOCATION (City, town, or county) (State) <b>North Carolina</b>		24E. FUNERAL DIRECTOR <b>J. L. Brown</b>		24F. ADDRESS <b>108 W. Montgomery St</b>	

DATE RECEIVED BY LOCAL REGISTRAR **OCT 11 1950**  
 REGISTRAR'S SIGNATURE *William V. Smith*  
 97024  
 112.0

MEDICAL CERTIFICATION

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

DATE OF BIRTH

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

CC 100

B260  
JL- 113936BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8722  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Geraldine Booker Or Geraldine L.J. Booker</b>			2. DATE OF DEATH <b>10-10-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto. City</b>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>17-01</b>		
Length of stay in Baltimore <b>13 yrs.</b> Yrs. Mos. Days			O. STREET ADDRESS (If rural, give location) <b>952 Druid Hill Ave.</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>April 2, 1932</b>	9. AGE (In years last birthday) <b>18</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>			11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Joseph Booker</b>			14. MOTHER'S MAIDEN NAME <b>Roberta ?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>B. C. H. Records, 4940 Eastern Ave.</b>			ADDRESS		

18. **002X**

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Pulmonary Tuberculosis****At least 4 yrs.**

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **9-19-47**, 19 **50**, to **Oct. 10**, 19 **50**, that I last saw the deceased alive on **10-10**, 19 **50** and that death occurred at **1.55 p.m.** from the causes and on the date stated above.

23A. SIGNATURE

**O. S. Rogers** M. D.

23B. ADDRESS

**4940 Eastern Ave.**

23C. DATE SIGNED

**10-10-50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

**Burial****10/13/1950****Mt Calvary Cem.****Brooklyn Md.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**Wm. H. Williams, Jr.****Shirley G. Gibson 1000 Beantley Ave**

SSA 71

SSA 71



N-520

50 8723

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8723

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES FRANK JONES

2. DATE  
OF  
DEATH

10-10-50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

UNION MEMORIAL HOSPITAL

43 Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

SEPARATED

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

27-15

d. STREET ADDRESS (If rural, give location)

4258 Falls Road

8. DATE OF BIRTH

3-5-1907

9. AGE (in years last birthday)

43

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cutting Mills - Weaver -

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF  
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Andrew F. Jones

14. MOTHER'S MAIDEN NAME

Helena Henckman HINZMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 162X

CAUSE OF DEATH

Hepatic insufficiency  
carcinoma of the lungINTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

generalized metastases

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21a. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-11, 1950, to 10-10, 1950, that I last saw the deceased alive on 10-10, 1950, and that death occurred at 5:15 P. m., from the causes and on the date stated above.

23a. SIGNATURE

Francis H. Wau

M. D.

23b. ADDRESS

Union Memorial Hosp.

23c. DATE SIGNED

10-10-50

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24b. DATE

10-13-1950

24c. NAME OF CEMETERY OR CREMATORY

Messiah Lutheran

24d. LOCATION (City, town, or county)

Berrett Carroll G. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams

25. FUNERAL DIRECTOR

ADDRESS

E. Milwitz Winfield. Md

VS 150

6844E

047a

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 8724  
Registered No. \_\_\_\_\_

BIRTH NO. 50 8724

1. NAME OF DECEASED (Type or Print) <u>William Michael Gould, Sr.</u>			2. DATE OF DEATH <u>Oct. 9, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR <del>INSTITUTION</del> <u>St. Joseph's</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>6-02</u>		
D. STREET ADDRESS (If rural, give location) <u>2740 E. Baltimore St.</u>					
5. Length of stay in Baltimore <u>60 yrs</u>			6. Length of stay in Baltimore <u>60 yrs</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 30, 1876</u>		9. AGE (In years; last birthday) <u>74</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Roller</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>William Gould</u>		
14. MOTHER'S MAIDEN NAME <u>Sabina Welsh</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>213-09-3520</u>			17. INFORMANT <u>2740 E. Baltimore St. Mrs. Ellen N. Gould</u>		

18. <u>180X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic carcinoma</u> DUE TO <u>hypernephroma, left</u>		INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <u>0</u> 19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from September 3, 1950, to October 9, 1950 that I last saw the deceased alive on Oct. 9, 1950, and that death occurred at 5:45 pm., from the causes and on the date stated above.

23A. SIGNATURE <u>Maddeus Swinski</u>	M. D. <u>1100 N. Caroline St.</u>	23C. DATE SIGNED <u>Oct. 9, 1950</u>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24B. DATE <u>10/13/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
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DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <u>William H. Williams, M.D.</u>	5. FUNERAL DIRECTOR <u>HENRY SANDER &amp; SONS, INC.</u>	ADDRESS <u>BALTO., 13, MD.</u>
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MEDICAL CERTIFICATION

NO 8731

DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1911

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Date of Death		Place of Death		Cause of Death	
Time of Death		Occupation		Manner of Death	
Physician's Signature		Physician's Name		Physician's Address	
Coroner's Signature		Coroner's Name		Coroner's Address	
Registrar's Signature		Registrar's Name		Registrar's Address	
Witness's Signature		Witness's Name		Witness's Address	

J-525

50 8725

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8725  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Annie Johnson

2. DATE  
OF  
DEATH

10/10/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Saul Baltimore General Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

23-01

Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

205 West Hamburg Street

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

6/30/1902

9. AGE (in years  
last birthday)

48

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John McConneaughey

14. MOTHER'S MAIDEN NAME

Susie

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

William Johnson

18. 171X I CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Generalized pelvic carcinomatous  
DUE TO Carcinoma of Cervix uteri

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Malnutrition

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 7/1/50, 19, to 10/10/50, 19, that I last saw the  
deceased alive on 10/10/50, 19, and that death occurred at 7:30 A. m., from the causes and on the date stated above.

23A. SIGNATURE

J. L. Hollister

23B. ADDRESS

1213 Light Street

23C. DATE SIGNED

10/10/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

10-14-1950 Mt. Auburn Cem Balto. Md

W. H. P. Williams P. Schorner St.

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>AUGUSTUS O. ARROWOOD</b>			2. DATE OF DEATH <b>October 1, 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>South Carolina</b> B. COUNTY <b>V-20</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Harbor at York St. &amp; Battery Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Great Falls Charlotte, Mecklenburg County</b>		
D. STREET ADDRESS (If rural, give location) <b>22 Church Street 517 E. 11th St.</b>			E. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug. 16, 1923</b>		9. AGE (In years last birthday) <b>27</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Textile Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Great Falls, S. C.</b>	
13. FATHER'S NAME <b>E. C. Arrowood</b>			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes War II</b>			14. MOTHER'S MAIDEN NAME <b>Crick Majors</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>E. C. Arrowood, 522 E. 11th St., Char-</b>		

18. <b>E929.8</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Drowning</b> DUE TO <b>(B)</b> DUE TO <b>(C)</b>		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>harbor</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>York Street and Battery Avenue 22-1</b>		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>Found: Oct. 1, 1950 10.20 a.m.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Found drowned</b>		

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>Stanley H. Dineen</b> M.D.	23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	23C. DATE SIGNED <b>Oct. 1, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24B. DATE <b>10/11/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>McEwen Funeral Home</b>
24D. LOCATION (City, town, or county) (State) <b>Charlotte, N. C.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Mildred T. Blight, 6009 Harford Rd</b>

DATE RECEIVED BY LOCAL REGISTRAR  
**OCT 11 1950**

REGISTRAR'S SIGNATURE

3572

11

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10 3728

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

SEX

AGE

RACE

RELIGION

OCCUPATION

EDUCATION

Marital Status

Place of Birth

Country of Birth

Year of Birth

Month of Birth

Day of Birth

Hour of Birth

Minute of Birth

Second of Birth

Third of Birth

Fourth of Birth

Fifth of Birth

Sixth of Birth

Seventh of Birth

Eighth of Birth

Ninth of Birth

Tenth of Birth

Eleventh of Birth

Twelfth of Birth

Thirteenth of Birth

Fourteenth of Birth

Fifteenth of Birth

Sixteenth of Birth

Seventeenth of Birth

Eighteenth of Birth

Nineteenth of Birth

Twentieth of Birth

Twenty-first of Birth

Twenty-second of Birth

Twenty-third of Birth

Twenty-fourth of Birth

Twenty-fifth of Birth

Twenty-sixth of Birth

Twenty-seventh of Birth

Twenty-eighth of Birth

Twenty-ninth of Birth

Thirtieth of Birth

Thirty-first of Birth

Thirty-second of Birth

Thirty-third of Birth

Thirty-fourth of Birth

Thirty-fifth of Birth

Thirty-sixth of Birth

Thirty-seventh of Birth

Thirty-eighth of Birth

Thirty-ninth of Birth

Fortieth of Birth

Forty-first of Birth

Forty-second of Birth

Forty-third of Birth

Forty-fourth of Birth

Forty-fifth of Birth

Forty-sixth of Birth

Forty-seventh of Birth

Forty-eighth of Birth

Forty-ninth of Birth

Fiftieth of Birth

Fifty-first of Birth

Fifty-second of Birth

Fifty-third of Birth

Fifty-fourth of Birth

Fifty-fifth of Birth

Fifty-sixth of Birth

Fifty-seventh of Birth

Fifty-eighth of Birth

Fifty-ninth of Birth

Sixtieth of Birth

Sixty-first of Birth

Sixty-second of Birth

Sixty-third of Birth

Sixty-fourth of Birth

Sixty-fifth of Birth

Sixty-sixth of Birth

Sixty-seventh of Birth

Sixty-eighth of Birth

Sixty-ninth of Birth

Seventieth of Birth

Seventy-first of Birth

Seventy-second of Birth

Seventy-third of Birth

Seventy-fourth of Birth

Seventy-fifth of Birth

Seventy-sixth of Birth

Seventy-seventh of Birth

Seventy-eighth of Birth

Seventy-ninth of Birth

Eightieth of Birth

Eighty-first of Birth

Eighty-second of Birth

Eighty-third of Birth

Eighty-fourth of Birth

Eighty-fifth of Birth

Eighty-sixth of Birth

Eighty-seventh of Birth

Eighty-eighth of Birth

Eighty-ninth of Birth

Ninetieth of Birth

Ninety-first of Birth

Ninety-second of Birth

Ninety-third of Birth

Ninety-fourth of Birth

Ninety-fifth of Birth

Ninety-sixth of Birth

Ninety-seventh of Birth

Ninety-eighth of Birth

Ninety-ninth of Birth

Hundredth of Birth







B-625  
50 8728BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>DAVID KERR BRYSON</b>			2. DATE OF DEATH <b>10-11-50</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____		
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>27-38</b>		
Length of stay in Baltimore _____ Yrs. _____ Mos. _____ Days _____			d. STREET ADDRESS (If rural, give location) <b>5800 Edgemoor Road</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>3-1-1907</b>	9. AGE (in years last birthday) <b>43</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager - Service Station</b>			11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		
10b. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>David Kerr Bryson Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Rachael Cooper</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>			16. SOCIAL SECURITY NO. <b>213-05-6920</b>		
17. INFORMANT <b>Alice L. Bryson</b>			ADDRESS <b>5800 Edgemoor Rd</b>		

## CAUSE OF DEATH

18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b> (A) _____ DUE TO	INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Essential Hypertension</b> (B) _____ DUE TO	<b>?</b>
(C) _____	

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

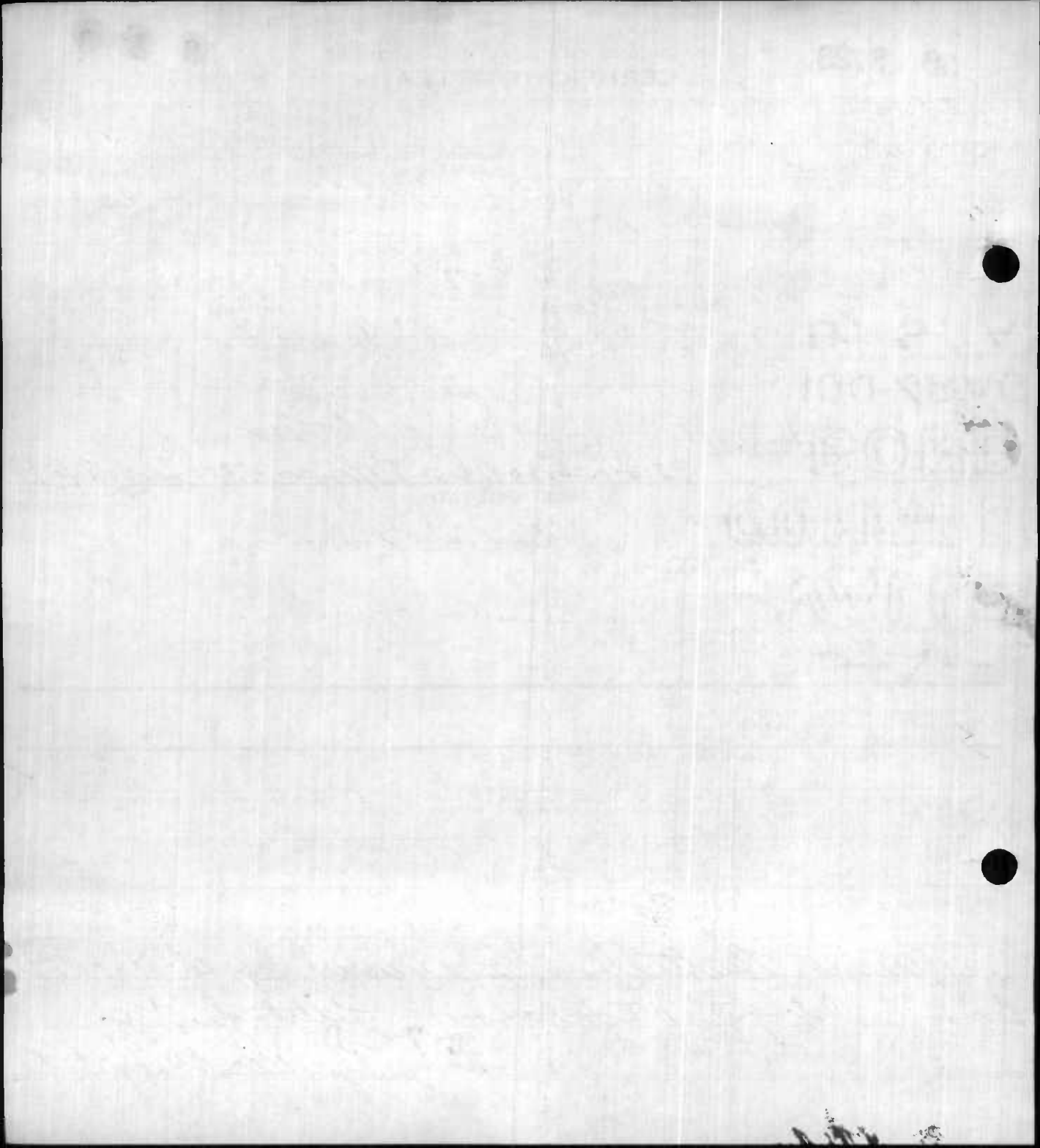
19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **10-10**, 19**50**, to **10-11**, 19**50**, that I last saw the deceased alive on **10-11**, 19**50**, and that death occurred at **2:15 P.m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>Wallace T. Buttrick M.D.</b>	23B. ADDRESS <b>Union Memorial Hospital</b>	23C. DATE SIGNED <b>Oct 11 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Oct. 13/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon</b>
24D. LOCATION (City, town, or county) (State) <b>Pittsburgh, Pa.</b>	25. FUNERAL DIRECTOR <b>Loring Myers</b>	ADDRESS <b>5005 Park Heights Ave</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>21950</b>	REGISTRAR'S SIGNATURE <b>Walter J. Miller</b>	

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 8729

BIRTH NO. 50 8729

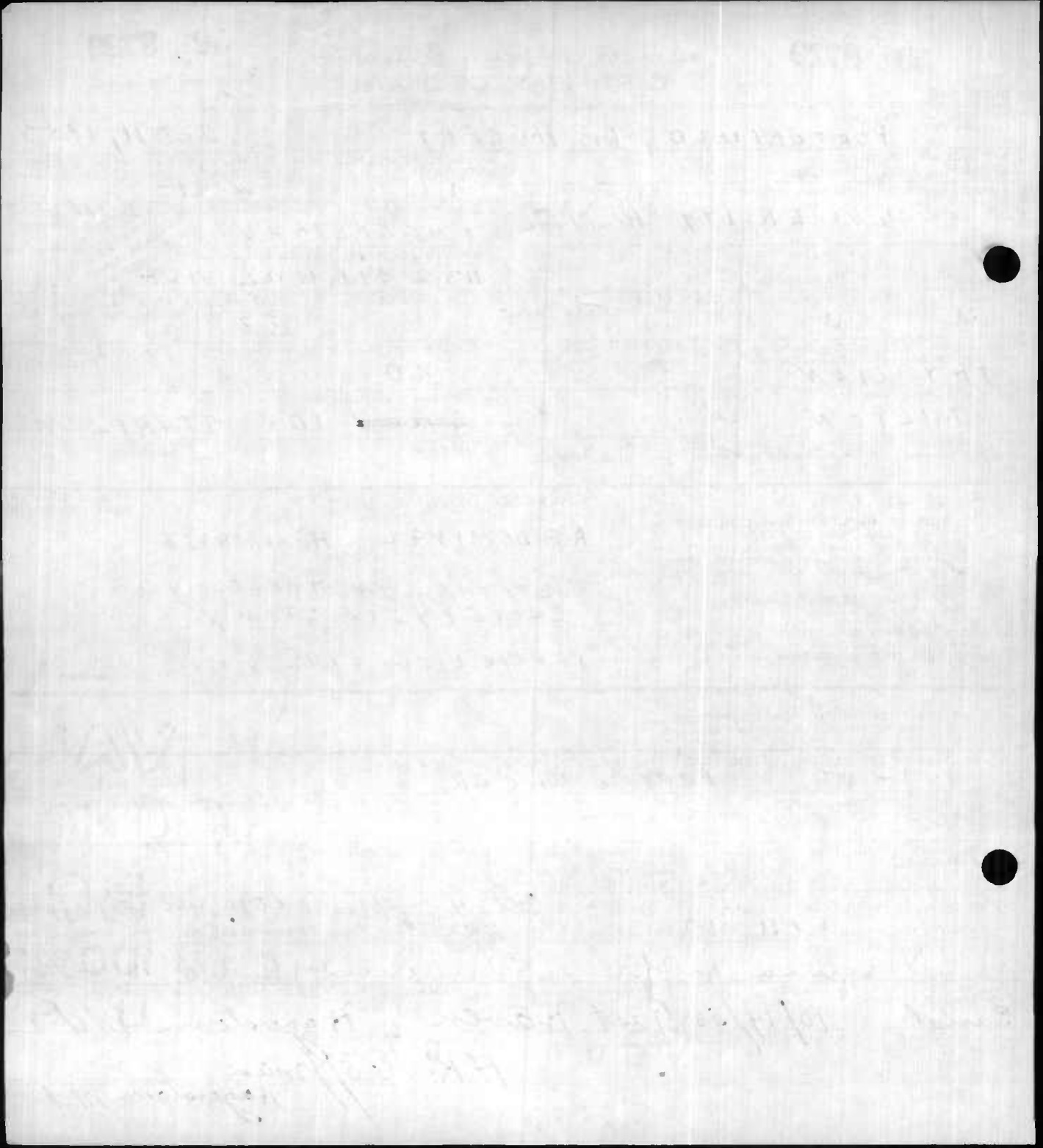
1. NAME OF DECEASED (Type or Print) <b>PORTERFIELD, Dr. HUBERT</b>			2. DATE OF DEATH <b>Oct 11, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>WASH</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>HAGERSTOWN 7103</b>		
Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>1132 OAK HILL AVE</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, <del>MARRIED</del> WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (in years last birthday) <b>50</b>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHYSICIAN</b>			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME <b>MILTON W.</b>			14. MOTHER'S MAIDEN NAME <del>SALLY</del> <b>IDA STARTZMAN</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT ADDRESS		

18. <b>540.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b>  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	<p align="center"><b>CAUSE OF DEATH</b></p> <p align="center"><b>AB DOMINAL HEMORRHAGE</b></p> <p>DUE TO <b>SUBTOTAL GASTRECTOMY + CHOLECYSTECTOMY</b></p> <p>DUE TO <b>PEPTIC ULCER + CHOLECYSTITIS</b></p>	INTERVAL BETWEEN ONSET AND DEATH
<p align="center"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>		

19A. DATE OF OPERATION <b>9-9-50</b>		19B. MAJOR FINDINGS OF OPERATION <b>PEPTIC ULCER</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDER- LYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Oct 4, 1950, to Oct 11, 1950, that I last saw the deceased alive on Oct 11, 1950, and that death occurred at 2:30 P m., from the causes and on the date stated above.

23A. SIGNATURE <i>Virginia Huffer</i> M. D.		23B. ADDRESS <i>University Hospital</i>		23C. DATE SIGNED <b>10-11-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Rural</i>	24B. DATE <b>10/14/50</b>	24C. NAME OF CEMETERY OR CREMATORY <i>Rest Haven</i>	24D. LOCATION (City, town, or county) (State) <i>Hagerstown Md</i>		
DATE RECEIVED BY LOCAL REGISTRAR <b>11-2-1950</b>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR <i>A. K. Hoffman</i> ADDRESS <i>Hagerstown Md 117a</i>			





B-200  
50 8730

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Louis C. Boss*

2. DATE  
OF  
DEATH

*OCT-9-1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

*UNIVERSITY of Maryland.*

C. Length of stay in Baltimore

*Life*

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*Maryland Anne Arundel*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Baltimore - Brooklyn Park*

D. STREET ADDRESS (If rural, give location)

*110 Cottagevale Road*

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

*Hot Flanger*

*MENS HATS INC.*

*Baltimore Md.*

*USA.*

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

*William F. Boss*

*Jennie Karkiere*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*212-09-3900 Pearl E. Boss*

*Same*

18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Coronary Artery Disease*

*3 yrs*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *1947*, 19 *50*, to *10/9*, 19 *50*, that I last saw the deceased alive on *10/9*, 19 *50*, and that death occurred at *12:15 pm.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

*Edward D. Kallen*

M. D.

*1847 W. North Ave*

*10/11/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Burial*

*Oct 12/1950*

*London Park Cem. Balto. Md.*

*Thurston Williams, M.D.*

*J. B. Wickett & Son*

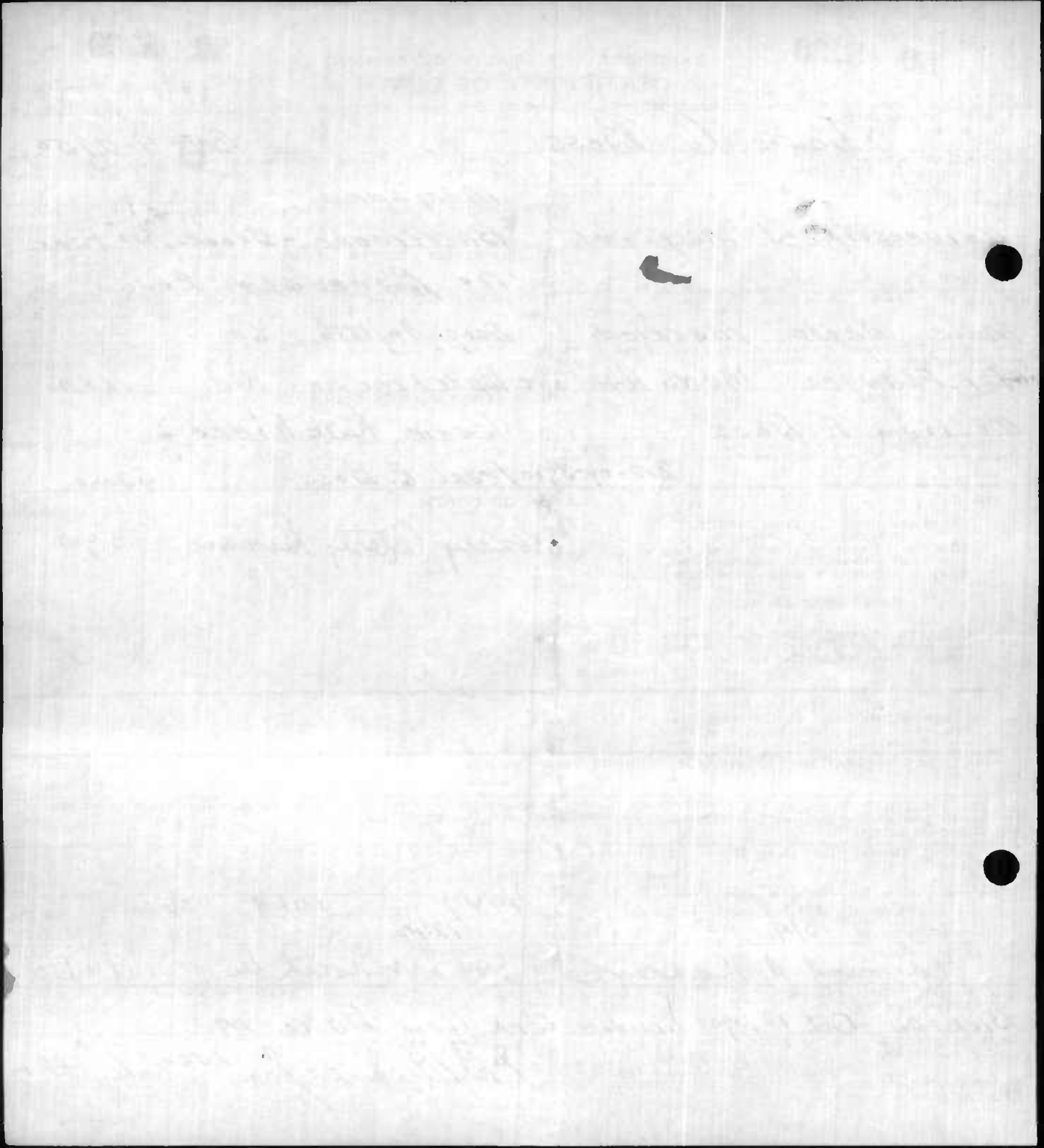
*1300 E. Calver St. 17*

OCT 12 1950

690 4F

94a

MEDICAL CERTIFICATION



F-426 8731

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8731  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

AMELIA FREISCHER

2. DATE  
OF  
DEATH

10-11-50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE

(Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

8. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2449 Shirley Ave

c. CITY, OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 1510

Length of stay in Baltimore

50 Yrs. 11 Mo. 15 Days

o. STREET ADDRESS (If rural, give location)

4008 Garrison Boulevard

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

11 Under 1 Year

11 Under 24 Hours

Female

White

Widow

80

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Home Wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Austria

13. FATHER'S NAME

Samuel

14. MOTHER'S MAIDEN NAME

Serina

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Paula Pierce - 4008 Garrison Blvd

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Acute Coronary Infarction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

Coronary Sclerosis

Chronic Myocardial Disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 8/7, 1950, to 10/7, 1950, that I last saw the deceased alive on 10/7, 1950, and that death occurred at 9:07 p.m., from the causes and on the date stated above.

23a. SIGNATURE

G. H. Hornstein

23b. ADDRESS

M. D.

204 E. Biddle St

23c. DATE SIGNED

10/12/50

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State)

Burial 10-12-50

Rose Dale

Baltimore

Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 12 1950

Funeral Home 2100 Eutan Pl

VS 150

93D

MEDICAL CERTIFICATION

Hornstone  
204 E Alder St

Hornstone  
101 9101

M-525

## BALTIMORE CITY HEALTH DEPARTMENT

50 8732

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

50-22173

1. NAME OF DECEASED  
(Type or Print)

Baby Boy Manson

2. DATE  
OF  
DEATH

Oct. 11, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore, Md

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)

A. STATE

B. COUNTY

Baltimore

Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

8-04

D. STREET ADDRESS (If rural, give location)

1413 N. COLLINGTON AVE.

Length of stay in Baltimore

1 1/2

5. SEX

Male

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Oct. 10, 1950

9. AGE (In years  
last birthday)

1 1/2 days

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Infant  
John Manson

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MARDEN NAME

Martha Hammons

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mother

Same

18. 776 X 1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Prematurity

INTERVAL BETWEEN  
ONSET AND DEATH

1 1/2 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 10, 1950, to Oct 11, 1950, that I last saw the  
deceased alive on Oct 11, 1950, and that death occurred at 4:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Wm. M. M. M.

M. D.

Mercy Hospital

Oct 11, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Burial

Oct 12, 1950

New Lutheran

Frederick Road

Leo S. Hook 1701-03 N. Patterson Park Ave

...

100



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 8733  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>DR. DAVID EMRICH WEGLEIN</b>		2. DATE OF DEATH <b>Oct 10<sup>th</sup> 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>2400 Linden Ln</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE _____ B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>DO</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>13-01</b>	
Length of stay in Baltimore <b>life time</b> Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>2400 Linden Ln</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>June 10<sup>th</sup> 1876</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Supvt of School</b>	9. AGE (In years last birthday) <b>74</b> If Under 1 Year: Months: _____ Days: _____ If Under 24 Hours: Hours: _____ Min: _____
13. FATHER'S NAME <b>Morris Weglein</b>		14. MOTHER'S MAIDEN NAME <b>Rosa Emrich</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
		17. INFORMANT <b>Mrs. Henrietta Weglein</b>	
		ADDRESS <b>2400 Linden Ln</b>	

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH  <b>Coronary occlusion (thrombosis)</b> (A) _____ DUE TO _____  <b>Coronary artery sclerosis (angina pectoris). Generalized arterio-sclerosis</b> (B) _____ DUE TO _____  <b>Hypertension</b> (C) _____	INTERVAL BETWEEN ONSET AND DEATH  <b>1 hr.</b>         <b>14 yrs.</b>
--	---	--

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **March 11**, 1920, to **Oct 10**, 1950, that I last saw the deceased alive on **Oct 10**, 1950, and that death occurred at **5 P.** m., from the causes and on the date stated above.

23A. SIGNATURE <b>Laurel P. Hamburger</b> M. D.		23B. ADDRESS <b>1207 Eutaw Place</b>		23C. DATE SIGNED <b>Oct 11/50</b>	
--	--	---	--	--------------------------------------	--

24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>Oct 13<sup>th</sup> 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Elmhurst</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 11 1950</b>		REGISTRAR'S SIGNATURE <b>W. H. ...</b>		25. FUNERAL DIRECTOR <b>Edw. ...</b>		ADDRESS <b>...</b>	

W/310

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

John Young

2. DATE  
OF  
DEATH

Oct 8, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

G.O.R.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

MARYLAND

B. COUNTY

Anne Arundel

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Pasadena

D. STREET ADDRESS (If rural, give location)

Pasadena A.A. Co. Md

5200

5. SEX

MALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Feb. 19-1887

9. AGE (In years last birthday)

63

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Lumber Handler

10B. KIND OF BUSINESS OR INDUSTRY

Lumber Co

11. BIRTHPLACE (State or foreign country)

St Marys Co Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 570.3  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

Volvulus of Sigmoid

INTERVAL BETWEEN ONSET AND DEATH

1 wk

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

CERTIFICATION APPROVED

William F. Rienshoff M. D.  
CHIEF OR ASST. MEDICAL EXAMINER11  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-8 1950, to 10-8 1950, that I last saw the deceased alive on 10-8 1950, and that death occurred at 8:05 P.M., from the causes and on the date stated above.

23A. SIGNATURE

William F. Rienshoff M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

10/9/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/12/1950

24C. NAME OF CEMETERY OR CREMATORY

Pasadena

24D. LOCATION (City, town, or county) (State)

Pasadena Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

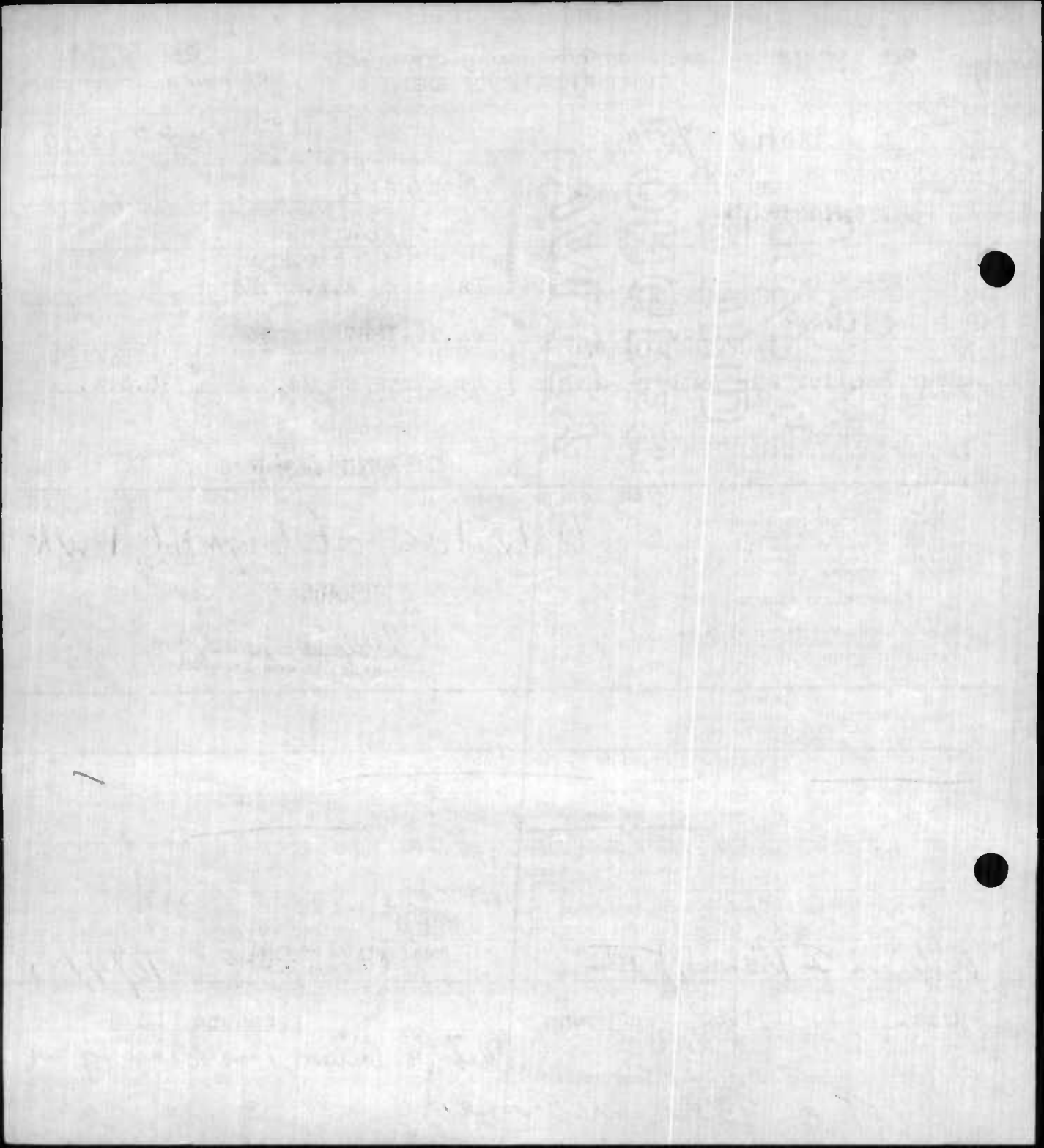
ADDRESS

OCT 12 1950

VS 150

To Be approved

122B



D-510

CERTIFICATE CORRECTED Oct. 17, 1950

BALTIMORE CITY HEALTH DEPARTMENT

50 8735

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

WOODROW WILSON IMHOFF

## 2. DATE

OF DEATH

September 23, 1950

## 3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Pier 4 Pratt Street

## 4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Texas

B. COUNTY

before admission)

## C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Beaumont

## D. STREET ADDRESS (If rural, give location)

983 North Street

Length of stay in Baltimore

Yrs.  
Mos.  
Days

## 5. SEX

male

## 6. COLOR OR RACE

white

## 7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

## 8. DATE OF BIRTH

July 25, 1917

## 9. AGE (In years

last birthday)

33 30?

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (State or foreign country)

Beaumont, Texas

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME

Frank C.

## 14. MOTHER'S MAIDEN NAME

Clara Rose

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

Yes

(If yes, give war or dates of service)

W.W. II

16. SOCIAL SECURITY NO.

983-09-8497

## 17. INFORMANT

ADDRESS

Veterans Administration (Mr. Myers)

18. E 929.8

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Drowning

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

## 19A. DATE OF OPERATION

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

harbor

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

Harbor at Pier 4 Pratt Street 4/1

21D. TIME (Month) (Day) (Year) (Hour)

Found: Sept. 23, 1950 m. 3:30 p.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparently accidentally fell into water

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒.

## 23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ M.D.

## 23C. DATE SIGNED

Sept. 27, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

## 24B. DATE

Oct 12 50

## 24C. NAME OF CEMETERY OR CREMATORY

Baltimore National

## 24D. LOCATION (City, town, or county) (State)

Baltimore - Md

DATE RECEIVED BY LOCAL REGISTRAR

OCT 12 1950

## REGISTRAR'S SIGNATURE

## 25. FUNERAL DIRECTOR

ADDRESS

Eusworth Amacost

VS 151

N-998 X

William W. Williams, M.D.

5118 Sursum - Oak Ave 183

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 8736

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CECELIA I RIGGIN</b>		2. DATE OF DEATH <b>10-10-50</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>TOWSON</b>	
d. STREET ADDRESS (If rural, give location) <b>533 SUSSEX ROAD 5300</b>		e. LENGTH OF STAY IN BALTIMORE <b>46</b> Yrs. Mos. Days	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>JUNE 16 1883</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>JOHN T. RIGGIN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	

18. <b>203X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Broncho pneumonia</b> DUE TO <b>Edema of lungs</b> DUE TO <b>multiple myeloma</b>	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19a. DATE OF OPERATION <b>10-7-50</b>	19b. MAJOR FINDINGS OF OPERATION <b>INCARCERATED BOWEL FEMORAL CANAL, LEFT</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from AUGUST 25, 1950, to October 10, 1950, that I last saw the deceased alive on October 10, 1950 and that death occurred at 6:40 p.m., from the causes and on the date stated above.

23a. SIGNATURE Francis H. Ware M. D. 23b. ADDRESS Union Memorial Hosp. 23c. DATE SIGNED 10-10-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Oct 13, 1950 24c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 24d. LOCATION (City, town, or county) (State) Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 12 1950 REGISTRAR'S SIGNATURE Hersey W. Fleckner & Sons Co 25. FUNERAL DIRECTOR ADDRESS 4905 York Rd.

55E

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The objectives of the project are stated in terms of the results to be achieved.

2. The second part of the report is a description of the methods used in the study. It includes a description of the experimental design, the data collection methods, and the statistical methods used to analyze the data.

3. The third part of the report is a description of the results of the study. It includes a description of the data collected, a summary of the findings, and a discussion of the implications of the results.

4. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides a final statement of the results. The references list the sources of information used in the study.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>MARGARETTA DIXEY PASSANO</b>			2. DATE OF DEATH <b>Oct. 10, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>5505 Jonquil Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
D. STREET ADDRESS (If rural, give location) <b>5505 Jonquil Ave.</b>			27-19		
5. SEX <b>female</b>			6. COLOR OR RACE <b>white</b>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>			8. DATE OF BIRTH <b>Oct. 24, 1872</b>		
9. AGE (In years last birthday) <b>77</b>			10. Under 1 Year Months: _____ Days: _____		
11. Under 24 Hours Hours: _____ Min: _____			12. CITIZEN OF WHAT COUNTRY? _____		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>			10B. KIND OF BUSINESS OR INDUSTRY _____		
13. FATHER'S NAME <b>Joseph of Leonard Passano</b>			14. MOTHER'S MAIDEN NAME <b>Parthenia Sewell Crawford Passano</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. _____		
17. INFORMANT <b>Mrs. Joseph S. Passano</b>			ADDRESS <b>5505 Jonquil Ave.</b>		

18. **174X** CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  
(A) **Mitotachi carcinoma of**  
DUE TO **Abdomen, from return**

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

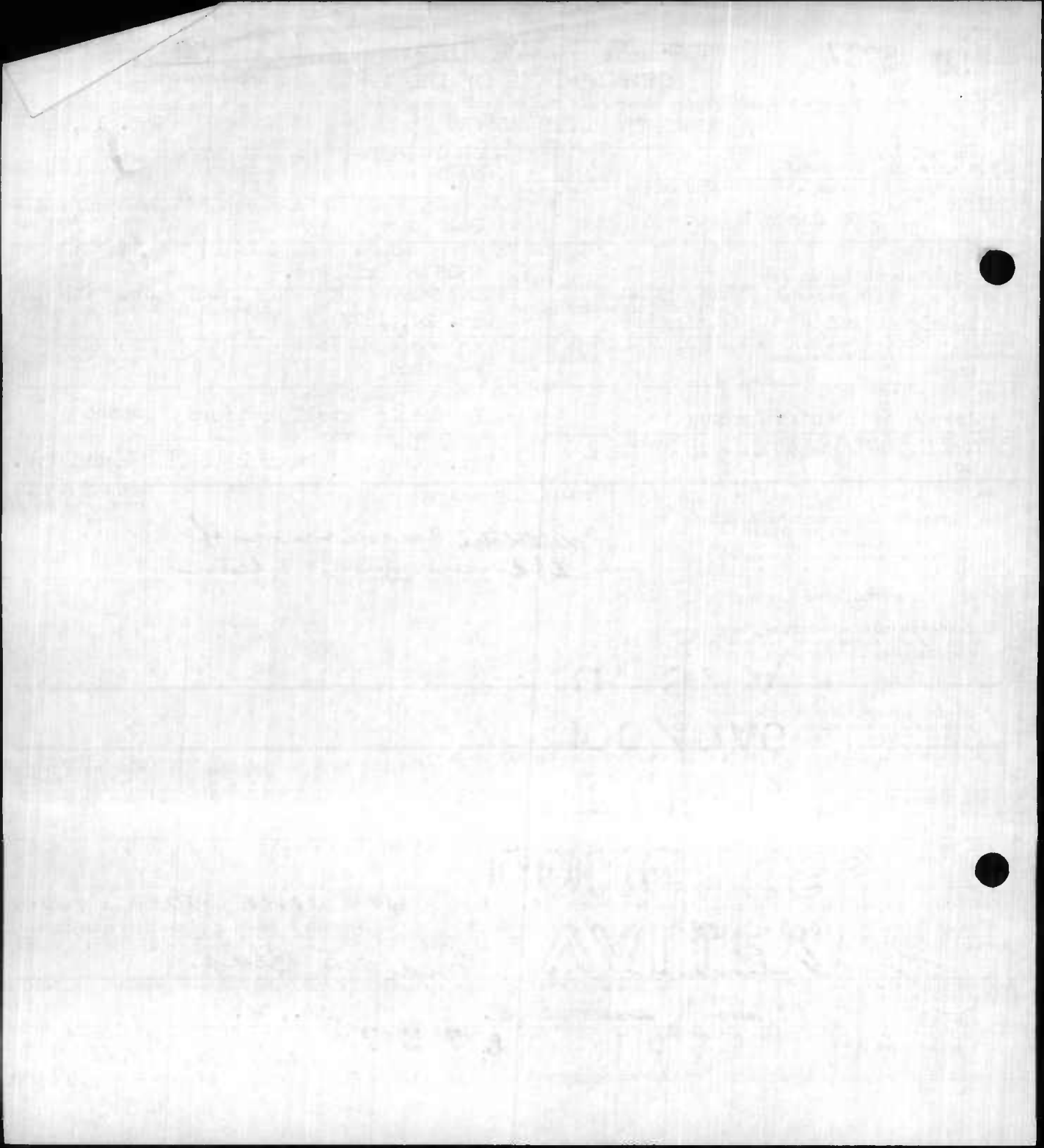
(B) \_\_\_\_\_  
DUE TO \_\_\_\_\_  
(C) \_\_\_\_\_

INTERVAL BETWEEN ONSET AND DEATH  
\_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
\_\_\_\_\_

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <b>1, 2</b> , 19 <b>50</b> , to <b>10.10</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>10 9</b> , 19 <b>50</b> , and that death occurred at _____ m., from the causes and on the date stated above.					
23A. SIGNATURE <b>M. J. Tamm</b>		23B. ADDRESS <b>Md. City Bldg.</b>		23C. DATE SIGNED _____	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/13/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 12 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Fickner</b>		FUNDAL DIRECTOR <b>Wm. J. Fickner</b>		ADDRESS <b>Wm. J. Fickner</b>	



P-300

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8738  
Registered No.

BIRTH NO. 50-22413

1. NAME OF DECEASED  
(Type or Print)

Baby girl Paddy (Paddy)

2. DATE  
OF  
DEATH

10-11-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

BON SECOURS Hospt.

Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

John J. Paddy

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

10-2-50

9. AGE (In years;  
last birthday)

-

11 Under 1 Year  
Months Days

- 9

12 Under 24 Hours  
Hours Min.

-

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Margaret Emala

17. INFORMANT

ADDRESS

Mr. John J. Paddy 4508 Mt. View Rd.

18. 764.5

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Acute gastroenteritis

DUE TO

3 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Pre-maturity

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-9, 1950, to 10-11, 1950, that I last saw the  
deceased alive on 10-11, 1950, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

M. D.

10-11-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

10/12/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Sickener &amp; Sons - Balto. Md.

8728 9

DEPARTMENT OF HEALTH & HUMAN SERVICES

CERTIFICATE OF DEATH

8728 9

11/18/87

1. NAME OF DECEASED [Faint text]	
2. SEX [Faint text]	
3. AGE [Faint text]	
4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]	
6. MARITAL STATUS [Faint text]	
7. OCCUPATION [Faint text]	
8. CAUSE OF DEATH [Faint text]	
9. MANNER OF DEATH [Faint text]	
10. SIGNATURE OF DECEASED [Faint text]	
11. SIGNATURE OF WITNESS [Faint text]	
12. SIGNATURE OF PHYSICIAN [Faint text]	
13. SIGNATURE OF CORONER [Faint text]	
14. SIGNATURE OF JUDGE [Faint text]	
15. SIGNATURE OF CLERK [Faint text]	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

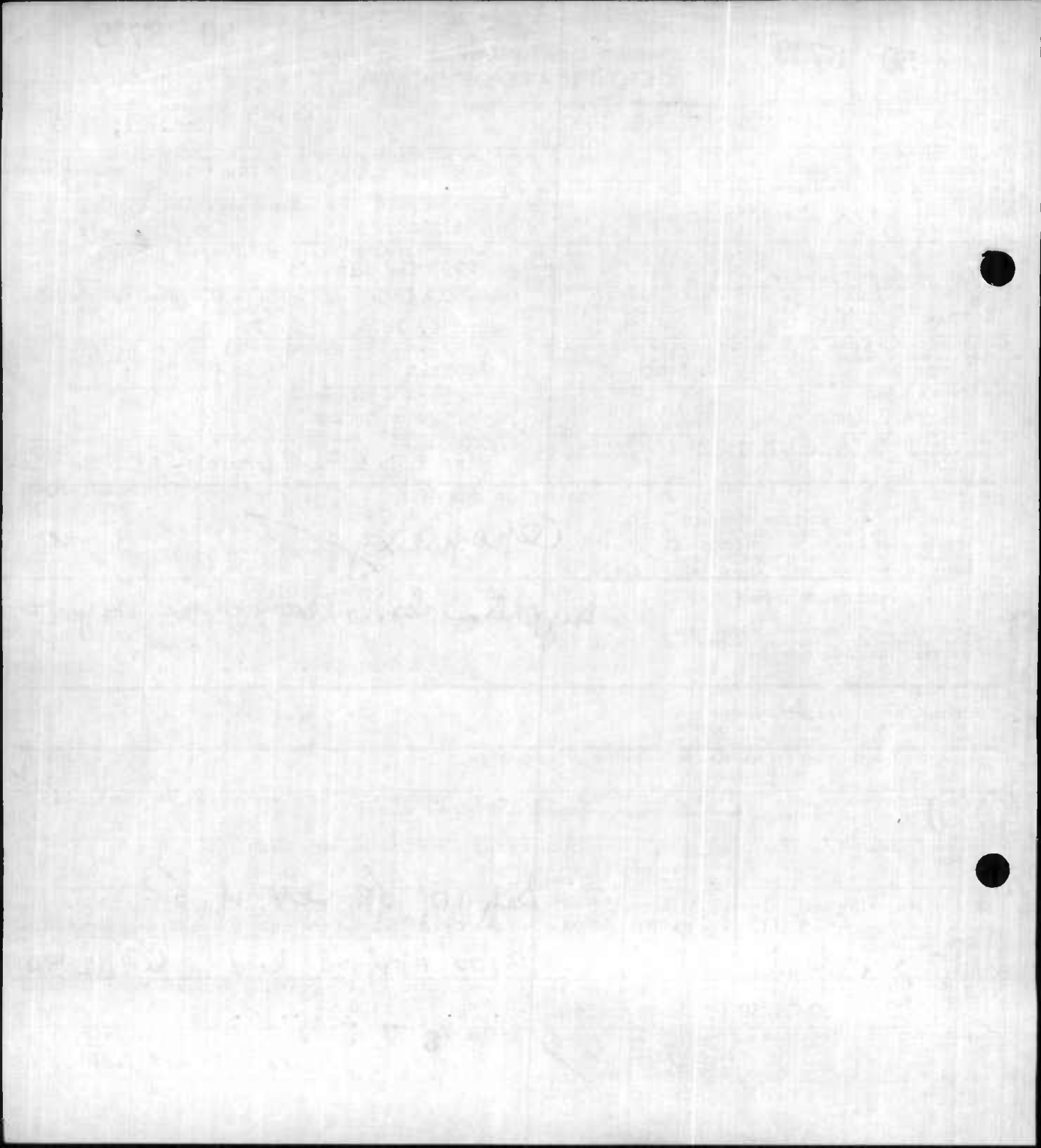
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>ANTOINETTE HOLZAPFEL</b>		2. DATE OF DEATH <b>Oct. 11, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>2792 The Alameda</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
6. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>2792 The Alameda</b>	
7. SEX <b>female</b>	8. COLOR OR RACE <b>white</b>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	10. DATE OF BIRTH <b>June 4, 1876</b>
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		12. AGE (In years last birthday) <b>74</b>	
13. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		14. BIRTHPLACE (State or foreign country) <b>Austria</b>	
15. FATHER'S NAME <b>George Malner</b>		16. CITIZEN OF WHAT COUNTRY? _____	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		18. SOCIAL SECURITY NO. _____	
19. MOTHER'S MAIDEN NAME <b>Gertrude Knauss</b>		20. INFORMANT <b>Miss Wilhelmina Holzapfel - 2792 The Alameda</b>	

18. <b>443x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cholelithiasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>
CAUSE OF DEATH (A) <b>Cholelithiasis</b> DUE TO _____		
(B) <b>Hypertensive Cardiovascular disease</b> DUE TO _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		<b>4 yw</b>
(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Sept 10, 1950</b> to <b>Oct 11, 1950</b> , that I last saw the deceased alive on <b>Oct 10, 1950</b> and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.					
23A. SIGNATURE <b>Dr. J. H. Hansen</b>		23B. ADDRESS <b>2700 Norfolk Rd</b>		23C. DATE SIGNED <b>Oct 12 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/14/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Pk.</b>	
24D. LOCATION (City, town, or county) <b>Balto., Md.</b>		24E. NAME OF FUNERAL DIRECTOR <b>Wm. J. Pickner &amp; Sons</b>		24F. ADDRESS <b>Balto. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 12 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Pickner</b>		25. FUNERAL DIRECTOR'S ADDRESS <b>Balto. Md.</b>	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Cleve Adams

2. DATE  
OF  
DEATH

10-10-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

936 Brevard Street (17)

Length of stay in Baltimore

14 Yrs.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

Sept. 17, 1907

9. AGE (In years last birthday)

43

If Under 1 Year Months Days  
If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Tyce Adams

14. MOTHER'S MAIDEN NAME

Isabelle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS 4940

Records\* Balto. City Hospitals Eastern Ave

18. 019-2-002X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Miliary Tuberculosis of Lungs

6 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

22. I hereby certify that I attended the deceased from 7-12, 1950, to 10-10, 1950, that I last saw the deceased alive on 10-10, 1950, and that death occurred at 2:30 P.M. from the causes and on the date stated above.

23A. SIGNATURE

*W. H. Kelser*

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

10-11-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

11-12-1950

1303 Pressman St



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 8741

BIRTH NO. P. 620  
50 8741

1. NAME OF DECEASED  
(Type or Print) JOHN. C. PREIS

2. DATE OF DEATH Oct. 12, 1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE MARYLAND B. COUNTY —

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

Length of stay in Baltimore Life

O. STREET ADDRESS (If rural, give location)  
521 South Bradford Street.

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Single

8. DATE OF BIRTH  
11-1-93

9. AGE (in years last birthday)  
56

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Lithographer

10B. KIND OF BUSINESS OR INDUSTRY  
Nat. Can. Co.

11. BIRTHPLACE (State or foreign country)  
Baltimore

12. CITIZEN OF WHAT COUNTRY?  
USA

13. FATHER'S NAME  
Joseph Preis

14. MOTHER'S MAIDEN NAME  
Katherine Wossler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
World War # 1

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
William Preis, 521 S. Bradford Street

18. 162X  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

(A) Carcinomatosis

4 months

19. DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Brachogenic carcinoma

Unknown

20. DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION  
NONE

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 5, 1950, to Oct. 12, 1950, that I last saw the deceased alive on Oct. 12, 1950, and that death occurred at 2A m., from the causes and on the date stated above.

23A. SIGNATURE  
Robert T. Parker

23B. ADDRESS  
University Hospital

23C. DATE SIGNED  
Oct 13 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

24B. DATE  
10-14-50

24C. NAME OF CEMETERY OR CREMATORY  
Schwartz's

24D. LOCATION (City, town, or county) (State)  
Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE  
William J. Parker

25. FUNERAL DIRECTOR ADDRESS  
403 S. Wolfe Street

OCT 17 1950

57135D

47c

1941

1941

1941

1941

1941

1941

1941

1941

*[Handwritten signature]*



520

50 8742

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

George Wm Thomas

2. DATE  
OF  
DEATH

October 8, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

1310 N. Stricker St.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

15-01

D. STREET ADDRESS (If rural, give location)

1310 N. Stricker St.

C. Length of stay in Baltimore

50

Yrs.

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1-10-1875

9. AGE (in years  
last birthday)

75

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR  
INDUSTRY

Self

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Allen T Thomas

14. MOTHER'S MAIDEN NAME

Lettie Hawkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Gertrude Jones - 831 N. Gilman St.

18. 442X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

hypertensive  
cardio-renal disease

2 years

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

arterio-sclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6.30, 1950, to 10.8, 1950, that I last saw the  
deceased alive on 10.6, 1950, and that death occurred at 12 Mm., from the causes and on the date stated above.

23A. SIGNATURE

[Signature]

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 12 1950

[Signature]

[Signature] 1412 E. Preston St.

VS 150

131a

MEDICAL CERTIFICATION

George W. Thomas

1810 N. 5th St.

Male Colored Married

Allen J. Thomas

Letter H. H. H. H.

Mr. George Jones - 231 N. 5th St.

October 9, 1900

Maryland

Baltimore

1810 N. 5th St.

1-10-1900

Maryland

George W. Thomas - 1810 N. 5th St.  
Allen J. Thomas - 1810 N. 5th St.

320

50 8743

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8743

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>William Richard Keatts</b>		2. DATE OF DEATH <b>10/10/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>3-02</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>320 S. Exeter st.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
Length of stay in Baltimore <b>50 yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>320 S. Exeter St.</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 14 1875</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman (retired)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Sea Food</b>	9. AGE (In year - last birthday) <b>75</b>
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William C. Keatts</b>		14. MOTHER'S MAIDEN NAME <b>Mary K. Shelton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Florence Sheridan Keatts</b>		ADDRESS <b>320 S. Exeter street</b>	

18. <b>421.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac dilatation</b>	CAUSE OF DEATH <b>Cardiac dilatation</b>	INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Myocarditis + endocarditis</b>	(A) DUE TO <b>Myocarditis + endocarditis</b>	<b>about 2 years</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(B) DUE TO <b>Myocarditis</b>	
	(C) DUE TO	

19A. DATE OF OPERATION <b>None</b>	19B. MAJOR FINDINGS OF OPERATION <b>None</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>No Accident</b>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>May 4, 1947</b> to <b>Oct 10, 1950</b> that I last saw the deceased alive on <b>Oct 9, 1950</b> , and that death occurred at <b>Baltimore, Md.</b> from the causes and on the date stated above.		
23A. SIGNATURE <b>B. Kelly</b>	23B. ADDRESS <b>102 N. Union St. Baltimore, Md.</b>	23C. DATE SIGNED <b>Oct 11/50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>10-13-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mount Carmel Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	25. FUNERAL DIRECTOR <b>Charles J. Grandy &amp; Son Inc</b>	ADDRESS <b>118 W. Mt. Royal Ave</b>

[illegible]

1875

1871

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*William Gittings*

2. DATE  
OF  
DEATH

*10/10/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*D. O. A. Mercy Hospital*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*Parkwood Rd. #12*

Length of stay in Baltimore

*life*

5. SEX

*M.*

6. COLOR OR RACE

*W.*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*married*

8. DATE OF BIRTH

*4/23/1896*

9. AGE (In years, last birthday)

*54*

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*clerk*

10B. KIND OF BUSINESS OR INDUSTRY

*Superior Court*

11. BIRTHPLACE (State or foreign country)

*1896 Balto. Md.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Wm W. Gittings*

14. MOTHER'S MAIDEN NAME

*Annie Winters*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*Acute Pulmonary Embolism*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

*Hypertensive Crisis - Vascular Disease*

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

*Old Myocardial Infarction*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

*Thomas B. Connor*

*Mary Hospital*

*10/10/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

*Burial*

*10/13/50*

*U. S. National*

*Balto. Md.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Oct 12 1950*

*William W. Gittings*

*Wm Connor Inc. 1217 St. Paul St.*

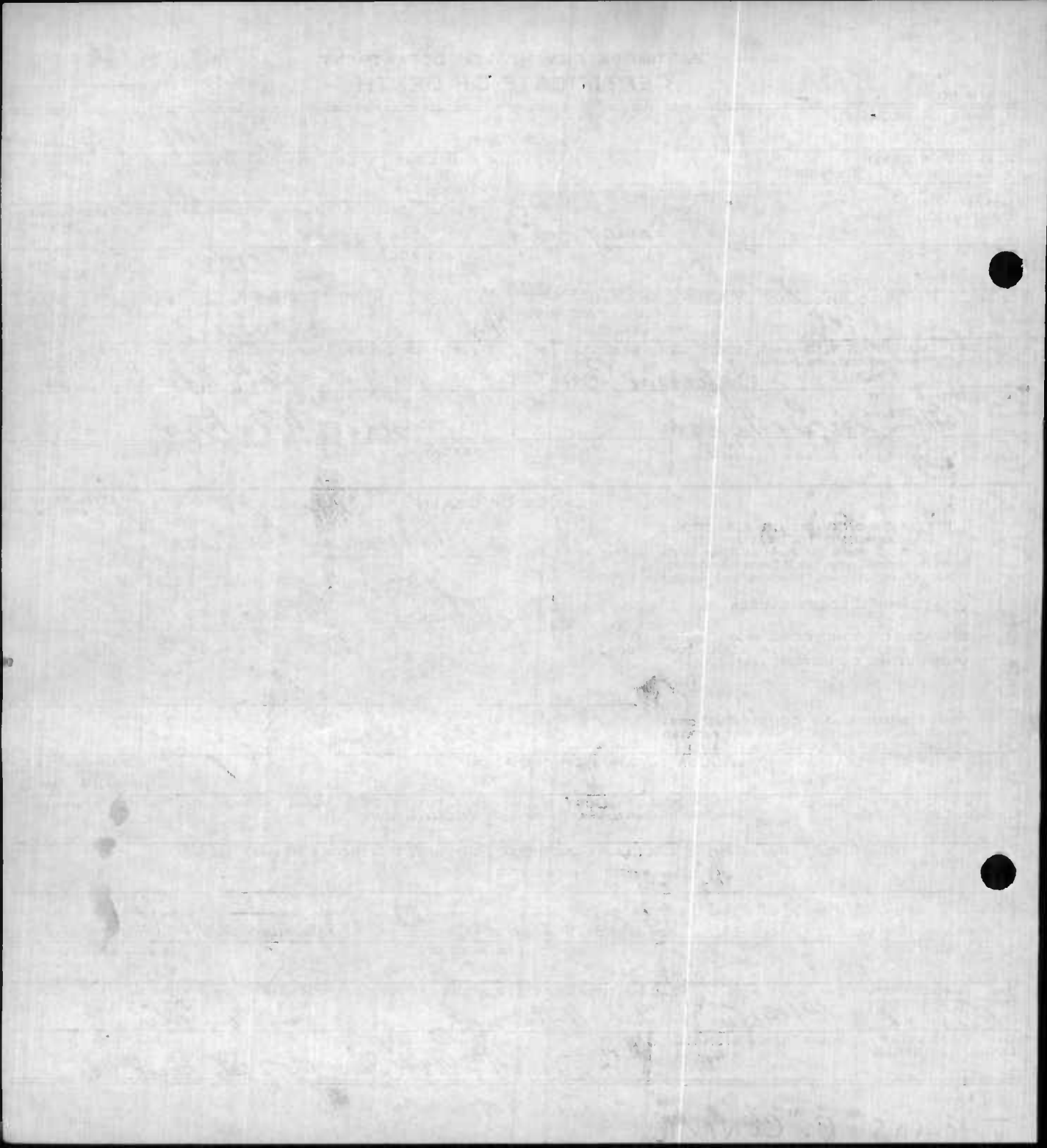
VS 150

THOMAS B. CONNOR

25092

093d

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Margaret Estelle Dean*

2. DATE  
OF  
DEATH

*October 11, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

*Md.*

B. COUNTY

*21-01*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Balto.*

D. STREET ADDRESS (If rural, give location)

*831 S. Paca st.*

B. FULL NAME OF (If not in hospital or institution, give street address or location)

*831 S. Paca st.*

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*Female*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Married*

B. DATE OF BIRTH

*10/7/1871*

9. AGE (In years last birthday)

*79*

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

*Own Home*

11. BIRTHPLACE (State or foreign country)

*Balto. Md.*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*George Switzer*

14. MOTHER'S MAIDEN NAME

*Mary A. (Unknown)*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

*No*

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Dorothy Dean 831 S. Paca st*

18. *422.1*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Acute Cardiac Failure*

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

*1 da*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Generalized Arteriosclerosis*

DUE TO

*Cardiovascular Disease*

*4 hr*

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *9/18* to *10/11*, 19*50*, that I last saw the deceased alive on *10/11*, 19*50*, and that death occurred at *5 p.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

*Burial*

*10/14/50*

*Mt. Olivet*

*Balto. Md.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*10/14/50*

*Wm Cook Inc 1217 St. Paul st*

*10/14/50*

*093d*

MEDICAL CERTIFICATION

Great Britain  
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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

John F. Wright

2. DATE OF DEATH  
Oct. 10, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

1530 Abbottston Street

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)  
1530 Abbottston Street

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

May 22, 1865

9. AGE (In years last birthday)

85

If Under 1 Year Months: Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

Self Employed

11. BIRTHPLACE (State or foreign country)

Eastern Shore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Levin Wright

14. MOTHER'S MAIDEN NAME

Sarah Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Mr. Wm. Schneider, 1530 Abbottston Street

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

7 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Oct 3, 1950, to Oct 10, 1950, that I last saw the deceased alive on Oct 9, 1950, and that death occurred at 7 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

10/13/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county) (State)

Parkville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook, Inc. 1217 St. Paul Street

VS 150

OCT 12 1950

094a

MEDICAL CERTIFICATION

STATE OF TEXAS

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

256  
AB-142430

50 8747

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 8747

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Evelyn Eisenhart

2. DATE  
OF  
DEATH

10-11-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE Baltimore City Hospitals

4940 Eastern Ave.

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

834 West 37th. Street

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

Feb. 21- 1929

9. AGE (In years  
last birthday)

21

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Norman ?

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.17. INFORMATION  
Baltimore City Hospitals  
Records: 4940 Eastern Ave.

18. 002X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis

DUE TO

Years ?

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-11-1950, to 10-11-1950 that I last saw the deceased alive on 10-11-1950, and that death occurred at 12.15 PM, from the causes stated on the date stated above.

23A. SIGNATURE

P. S. Rogers

M. D.

Baltimore City Hospitals  
4940 Eastern Ave.

23C. DATE SIGNED

10-11-1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

10/14/50

24C. NAME OF CEMETERY OR CREMATORY

Finkelsburg Meth.

24D. LOCATION (City, town, or county)

Finkelsburg Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William M. Williams

FEDERAL DIRECTOR

ADDRESS

Paul E. Schenck 3615-13 Street

OCT 12 1950

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20.50 8748  
BIRTH NO. 48-28671BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 8748

1. NAME OF DECEASED (Type or Print) <b>Ella Mae Black</b>		2. DATE OF DEATH <b>Oct. 12, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>5-07</b>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital (DOP)</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore City</b>	
Length of stay in Baltimore <b>2 yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>240 N. Coloma St.</b>	
SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE/MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>10/29/48</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>12</b>
13. FATHER'S NAME <b>James Black</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore md</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Anna Annis</b>	
17. INFORMANT <b>James Black</b>		ADDRESS <b>Balt. md. 240 N. Coloma St.</b>	

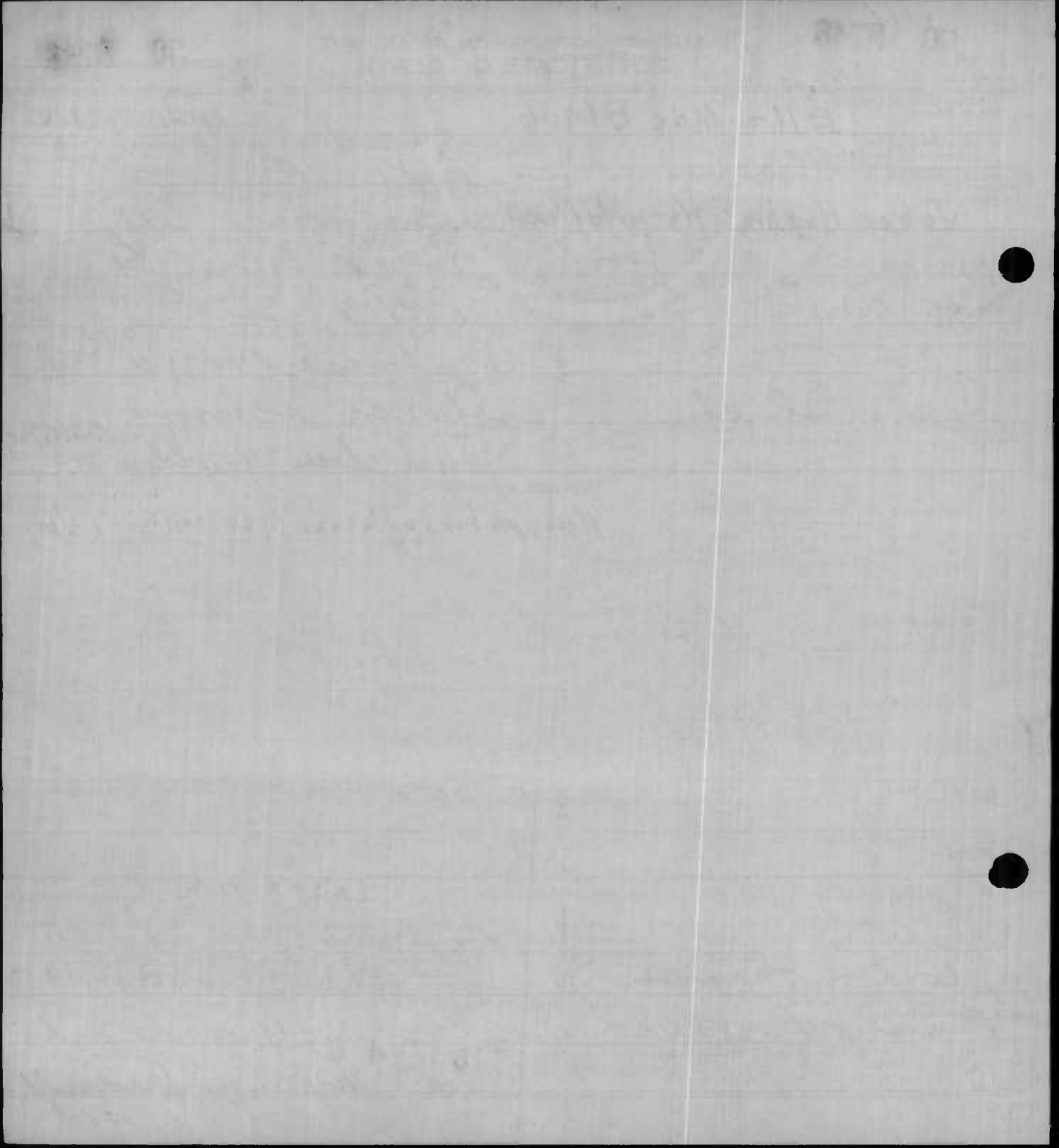
18. <b>340.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hemophilus Influenza Meningitis</b>	CAUSE OF DEATH (A) <b>Hemophilus Influenza Meningitis</b> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b>		(B) DUE TO
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATABLE TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO

19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Inspection** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>Wm. H. Rammer, Jr.</b> M.D.	23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input checked="" type="checkbox"/>	23C. DATE SIGNED <b>Oct. 12, 1950</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Oct. 14 50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>md. Olive Cem. New Windsor</b>	24D. LOCATION (City, town, or county) (State) <b>md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 13 1950</b>	REGISTRAR'S SIGNATURE <b>Wm. H. Rammer, Jr.</b>	25. FUNERAL DIRECTOR <b>J. S. Myers, Jr.</b>	ADDRESS <b>md.</b>



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>MARY BACOT PITTS</i>		2. DATE OF DEATH <i>Oct 11 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ind</i> B. COUNTY <i>12-01</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>100 N. University Pkwy.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
Length of stay in Baltimore <i>?</i> Yrs. <i>?</i> Mos. <i>?</i> Days <i>?</i>		D. STREET ADDRESS (If rural, give location) <i>100 N. University Pkwy</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>June 4 1879</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Balti Co Md</i>	
10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles H. Pitts</i>		14. MOTHER'S MAIDEN NAME <i>Mary B. Person</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>?</i>	
17. INFORMANT <i>James Piper Eccleston</i>		ADDRESS <i>Md.</i>	

MEDICAL CERTIFICATION

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Coronary Occlusion</i> DUE TO (B) <i>Arterio Sclerosis</i> DUE TO (C) <i>Hypertension</i>	INTERVAL BETWEEN ONSET AND DEATH <i>24 hr Oct 11 '50</i>  <i>1 year</i>
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19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *Jan 1st*, 1950 to *Oct 11th*, 1950, that I last saw the deceased alive on *Oct 10th*, 1950, and that death occurred at *100 N. University Pkwy.* m., from the causes and on the date stated above.

23A. SIGNATURE <i>J. A. Chataud</i>	M. O. <i>Ind</i>	23B. ADDRESS <i>15 E. Biddle St</i>	23C. DATE SIGNED <i>Oct 12/50</i>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Oct 14 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Green Mount</i>	24D. LOCATION (City, town, or county) (State) <i>Balti., Md</i>
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DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 13 1950</i>	REGISTRAR'S SIGNATURE <i>Washington B. B. B.</i>	25. FUNERAL DIRECTOR <i>Mary A. Jenkins</i>	ADDRESS <i>4905 York Rd.</i>
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Mr. Chatard  
15 E Biddle St

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

<b>1. NAME OF DECEASED</b> (Type or Print) <i>Mary F. Peyton</i>		<b>2. DATE OF DEATH</b> <i>Oct 12, 1950</i>	
<b>3. PLACE OF DEATH:</b> <b>A. Baltimore City, Maryland</b> <b>B. FULL NAME OF HOSPITAL OR INSTITUTION</b> <i>Senai</i>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <i>MARYLAND</i> <b>B. COUNTY</b> <i>Balto. Co.</i> <b>C. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give township) <i>Baltimore # 20</i> <b>D. STREET ADDRESS</b> (If rural, give location) <i>Madison River 5200</i>	
<b>5. SEX</b> <i>F</i> <b>6. COLOR OR RACE</b> <i>w</i> <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)</b> <i>Married</i> <b>Length of stay in Baltimore</b> <i>10</i> Yrs. Mos. Days		<b>8. DATE OF BIRTH</b> <i>1/5/1872</i> <b>9. AGE (In years last birthday)</b> <i>78</i> <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>housework</i> <b>10B. KIND OF BUSINESS OR INDUSTRY</b> <i>at home</i> <b>11. BIRTHPLACE</b> (State or foreign country) <i>Vir.</i> <b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>	
<b>13. FATHER'S NAME</b> <i>James Breeden</i> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <i>no</i> <b>16. SOCIAL SECURITY NO.</b> _____		<b>14. MOTHER'S MAIDEN NAME</b> <i>Lamb</i> <b>17. INFORMANT</b> <i>Wm. H. Peyton</i> <b>ADDRESS</b> <i>Senai Home</i>	

<b>18. 443X</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <i>Subarachnoid Hemorrhage</i> DUE TO _____ (B) <i>Hypertensive cardiovascular disease</i> DUE TO _____ (C) _____ <b>ANTECEDENT CAUSES</b> <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</b> _____ <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b> _____	<b>INTERVAL BETWEEN ONSET AND DEATH</b> _____
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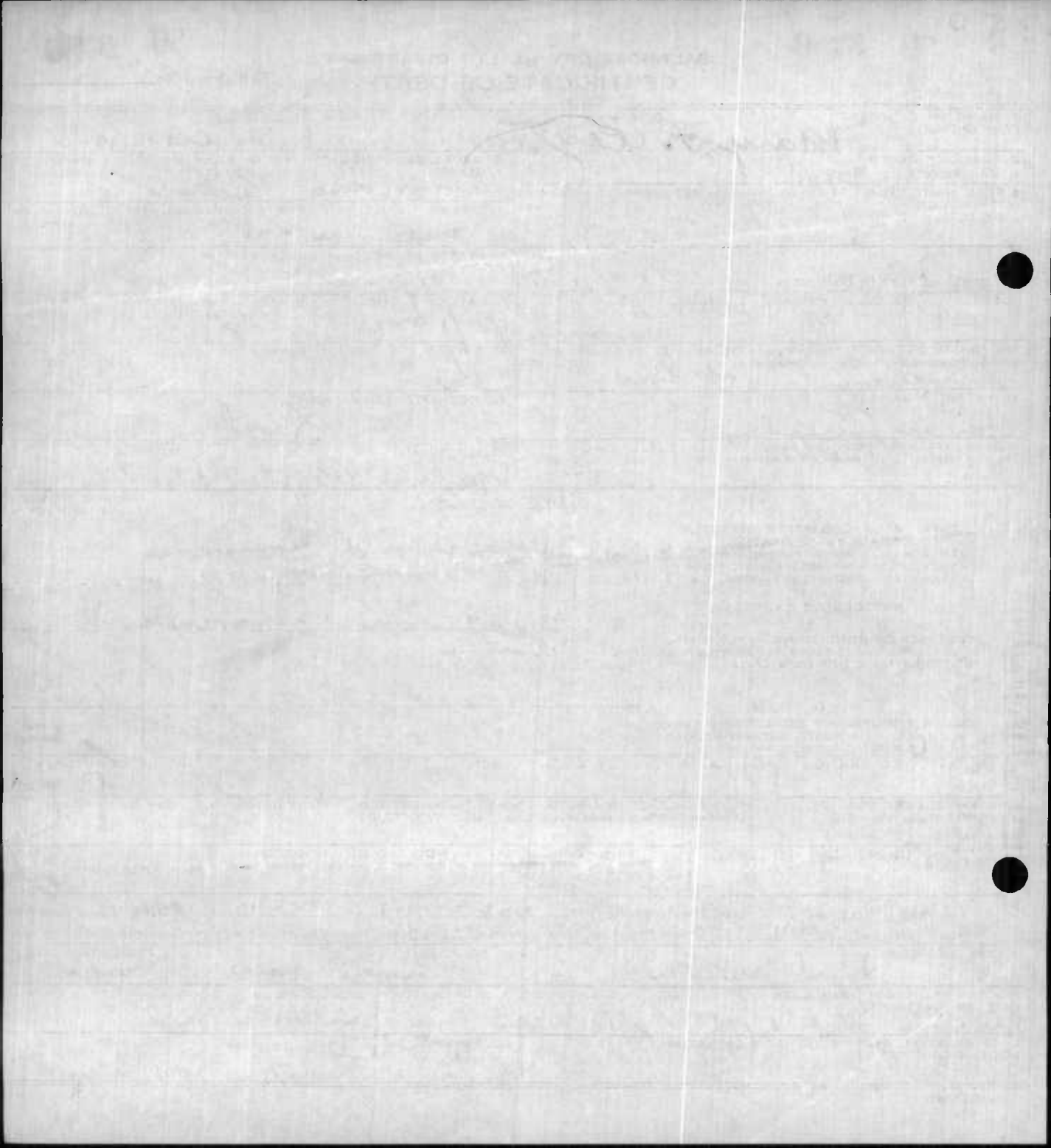
<b>19A. DATE OF OPERATION</b> <i>0</i>	<b>19B. MAJOR FINDINGS OF OPERATION</b> _____	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)</b> _____	<b>21B. PLACE OF INJURY</b> (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) _____
<b>21D. TIME (Month) (Day) (Year) (Hour) OF INJURY</b> _____	<b>21E. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21F. HOW DID INJURY OCCUR?</b> _____

**22. I hereby certify that I attended the deceased from** *Oct 2, 1950* **to** *Oct 12, 1950* **that I last saw the deceased alive on** *Oct 11, 1950* **and that death occurred at** *3:15 AM* **from the causes and on the date stated above.**

<b>23A. SIGNATURE</b> <i>Robert Sander</i>	<b>23B. ADDRESS</b> <i>Senai Home</i>	<b>23C. DATE SIGNED</b> <i>Oct 12</i>
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<b>24A. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i>	<b>24B. DATE</b> <i>Oct 15, 1950</i>	<b>24C. NAME OF CEMETERY OR CREMATORY</b> <i>Poplar Knuth. Cem.</i>	<b>24D. LOCATION (City, town, or county) (State)</b> <i>Balto. Co. Md.</i>
<b>DATE RECEIVED BY LOCAL REGISTRAR</b> <i>Oct 13 1950</i>	<b>REGISTRAR'S SIGNATURE</b> <i>Wm. H. Peyton</i>	<b>25. FUNERAL DIRECTOR</b> <i>Wm. H. Peyton</i> <b>ADDRESS</b> <i>Senai Home 7401 Belair Rd</i>	

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 8251

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLOTTE A. BENNION

2. DATE  
OF  
DEATH

Oct. 11th, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3719 Northern Parkway

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

3520 Hilton Road

Yrs.  
Mos.  
Days

Length of stay in Baltimore

life

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Aug. 7th, 1877

9. AGE (In years  
last birthday)

73

If Under 1 Year  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housework

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Bennion

14. MOTHER'S MAIDEN NAME

Ellen Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. Helen Deehring, 3719 Northern Pkwy.

18. 153x

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Carcinoma of Colon.

1 1/2 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Cardio-Vascular  
Renal Disease

2

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from 10/25, 1949, to 10/11, 1950, that I last saw the  
deceased alive on 10/10, 1949, and that death occurred at m. from the causes and on the date stated above.

23A. SIGNATURE

Joseph S. Blum

23B. ADDRESS

1115 N. Calver St.

23C. DATE SIGNED

10/11/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

Oct. 14, 1950

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cemetery

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

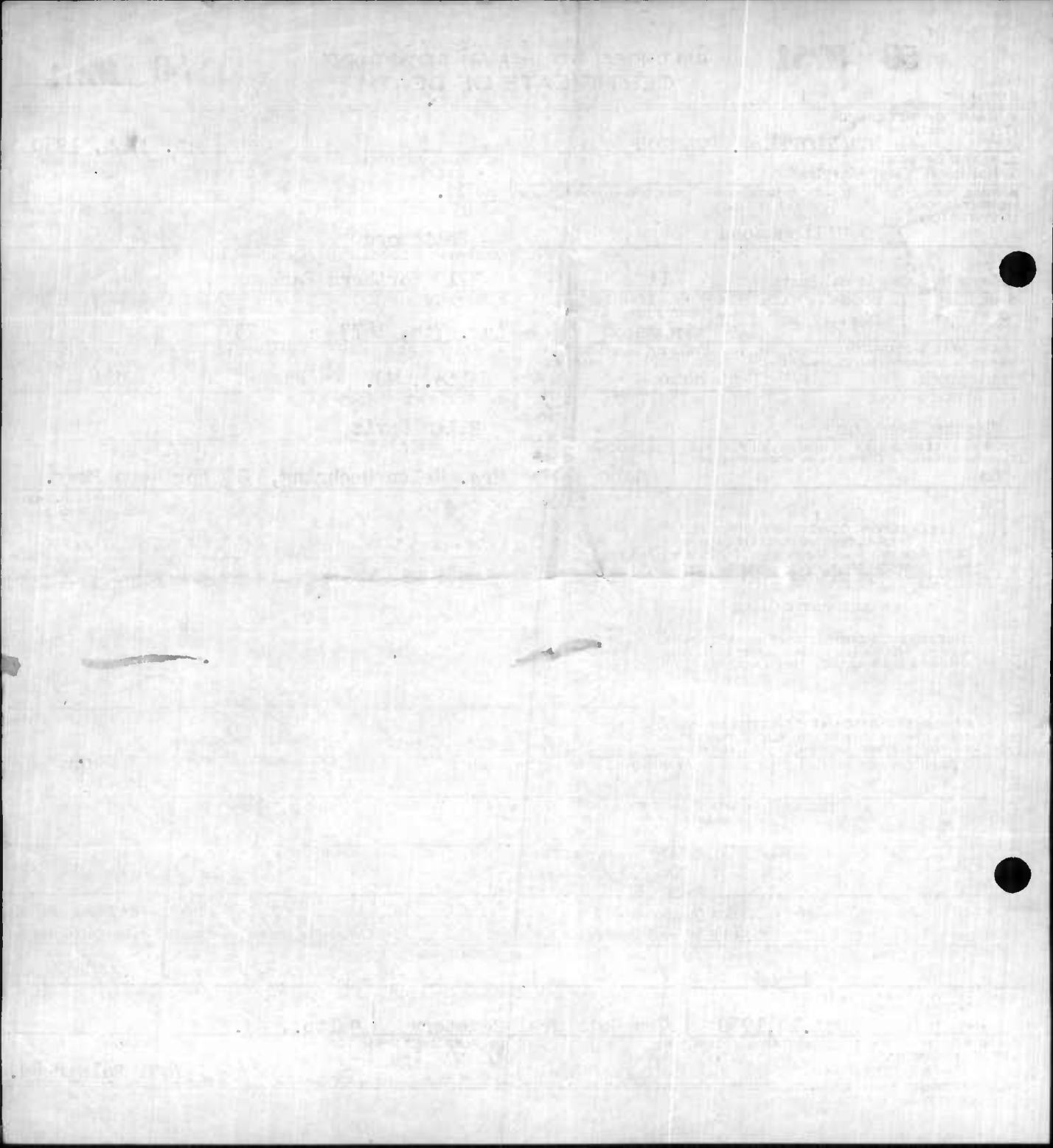
REGISTRAR'S SIGNATURE

Therese M. Williams

25. FUNERAL DIRECTOR

ADDRESS

Funeral Home 7401 Belair Rd.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 8752

BIRTH NO. 520

1. NAME OF DECEASED (Type or Print) <u>Fink, Marguerite Hammell</u>			2. DATE OF DEATH <u>Oct 10, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balto City</u>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>Women's Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
Length of stay in Baltimore <u>5 1/2</u> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <u>286 Laverne Ave</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 22, 1899</u>		9. AGE (in years last birthday) <u>51</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>H.W.</u>	11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Spencer Sparrow</u>			14. MOTHER'S MAIDEN NAME <u>Dora Clements</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>P. F. herself, 286 Laverne Ave</u>		

**CAUSE OF DEATH**

18. <u>550.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <u>Pulmonary embolus thrombo</u> DUE TO ANTECEDENT CAUSES (B) <u>Appendectomy</u> DUE TO (C) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (D) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (E) _____	INTERVAL BETWEEN ONSET AND DEATH <u>under 1 day</u>
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19A. DATE OF OPERATION <u>Sept. 16, 1950</u>	19B. MAJOR FINDINGS OF OPERATION <u>Appendiceal abscess; pelvic + intestinal adhesions</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? _____
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Sept 8, 1950, to Oct 10, 1950, that I last saw the deceased alive on Oct. 10, 1950, and that death occurred at 3:25 m., from the causes and on the date stated above.

23A. SIGNATURE Charles G. Smith M. D. Wm. H. Wm. of Md. 23C. DATE SIGNED Oct. 10, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Oct. 13/50.</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Landon</u>	24D. LOCATION (City, town, or county) (State) <u>Pk. 3801 Frederick Rd. Md.</u>
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DATE RECEIVED BY LOCAL REGISTRAR <u>Oct 13 1950</u>	REGISTRAR'S SIGNATURE <u>Harry H. Witzke</u>	25. FUNERAL DIRECTOR <u>4101 Edmonson Ave.</u>
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First, Wagoner, the

Wagoner Hospital

21st

Wagoner

H.W.

Wagoner Hospital

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 8753

BIRTH NO. 420

1. NAME OF DECEASED (Type or Print) <u>Charles E. T. Welch</u>		2. DATE OF DEATH <u>10-11-50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>BALTIMORE</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>2811 Overland</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>BALTIMORE 27-02</u>	
Length of stay in Baltimore <u>64</u> Yrs. <u>16</u> Mos. <u>14</u> Days		D. STREET ADDRESS (If rural, give location) <u>2811 Overland Ave</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Oct. 12, 1895</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Loader PENN. R.R.</u>		9. AGE (In years last birthday) <u>64</u>	
10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	
13. FATHER'S NAME <u>John Welch</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) _____		17. INFORMANT <u>Mrs. Mildred E Welch</u> ADDRESS <u>2811 Overland</u>	

18. <u>442X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) <u>Cordo-Vascular Lesal Disease</u> DUE TO _____
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) <u>Arteriosclerosis</u> DUE TO _____
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) <u>Hypertensive Arteritis</u>

19A. DATE OF OPERATION <u>10/10/50</u>		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from 9/10, 1950, to 10/11, 1950, that I last saw the deceased alive on 10/10, 1950, and that death occurred at 7 P. M., from the causes and on the date stated above.

23A. SIGNATURE <u>Joseph S. Bohm</u>	23B. ADDRESS <u>1115 H. Talbot St.</u>	23C. DATE SIGNED <u>10/11/50</u>
--------------------------------------	--	----------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10-14-1950</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Lorine Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore Co Md.</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>10/11/50</u>	REGISTRAR'S SIGNATURE <u>Joseph S. Bohm</u>	25. FUNERAL DIRECTOR <u>Emilio W. Conklin</u> ADDRESS <u>5444 Belair Rd</u>	

Dr. Blum 1115 N. Calvert St. 10 am



350

50 8754

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 8754

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

J. WILLIAM LAWTON

2. DATE  
OF  
DEATH

Oct. 12-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

MD.

24-03

B. FULL NAME OF (If not in hospital or institution, give street address or location)

137 E. WEST ST.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

137 E. WEST ST

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Sept. 18-1889

9. AGE (in years;  
last birthday)

61

10 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

ELECTRICAL

10B. KIND OF BUSINESS OR INDUSTRY

RAILROAD

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

RICHARD LAWTON

14. MOTHER'S MAIDEN NAME

MARY JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Frances Lawton 137 E. West St.

18. 002X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Pulmonary Tuberculosis

10 yrs?

DUE TO

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 1945, to Oct. 12, 1950, that I last saw the deceased alive on 10-12, 1950, and that death occurred at 10 A.M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

3105 Belair Rd

23C. DATE SIGNED

10-13-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

Oct. 16-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross Cem.

24D. LOCATION (City, town, or county) (State)

A.A.C.O. MD.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 13 1950

Elizabeth Harle Inc.

115 E. West St.

VS 150

51550

0136

MEDICAL CERTIFICATION

9th 10 AM Dr. Moore

3105 Belknap Rd.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>BECKER, ISAAC</b>		2. DATE OF DEATH <b>Oct 12 50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md</b> B. COUNTY <b>15-12</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Swan</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
Length of stay in Baltimore <b>60</b> Yrs. <b>2</b> Mos. <b>2</b> Days		D. STREET ADDRESS (If rural, give location) <b>3810 Park Heights Ave</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>7-8-18</b>
9. AGE (In years; last birthday) <b>32</b>		10. CITIZEN OF WHAT COUNTRY? <b>Russia</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Designer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	
11. FATHER'S NAME <b>Abraham</b>		12. MOTHER'S MAIDEN NAME <b>Cornue</b>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		14. SOCIAL SECURITY NO. <b>42010</b>	
15. INFORMANT <b>Belia Becker</b>		ADDRESS <b>Same</b>	

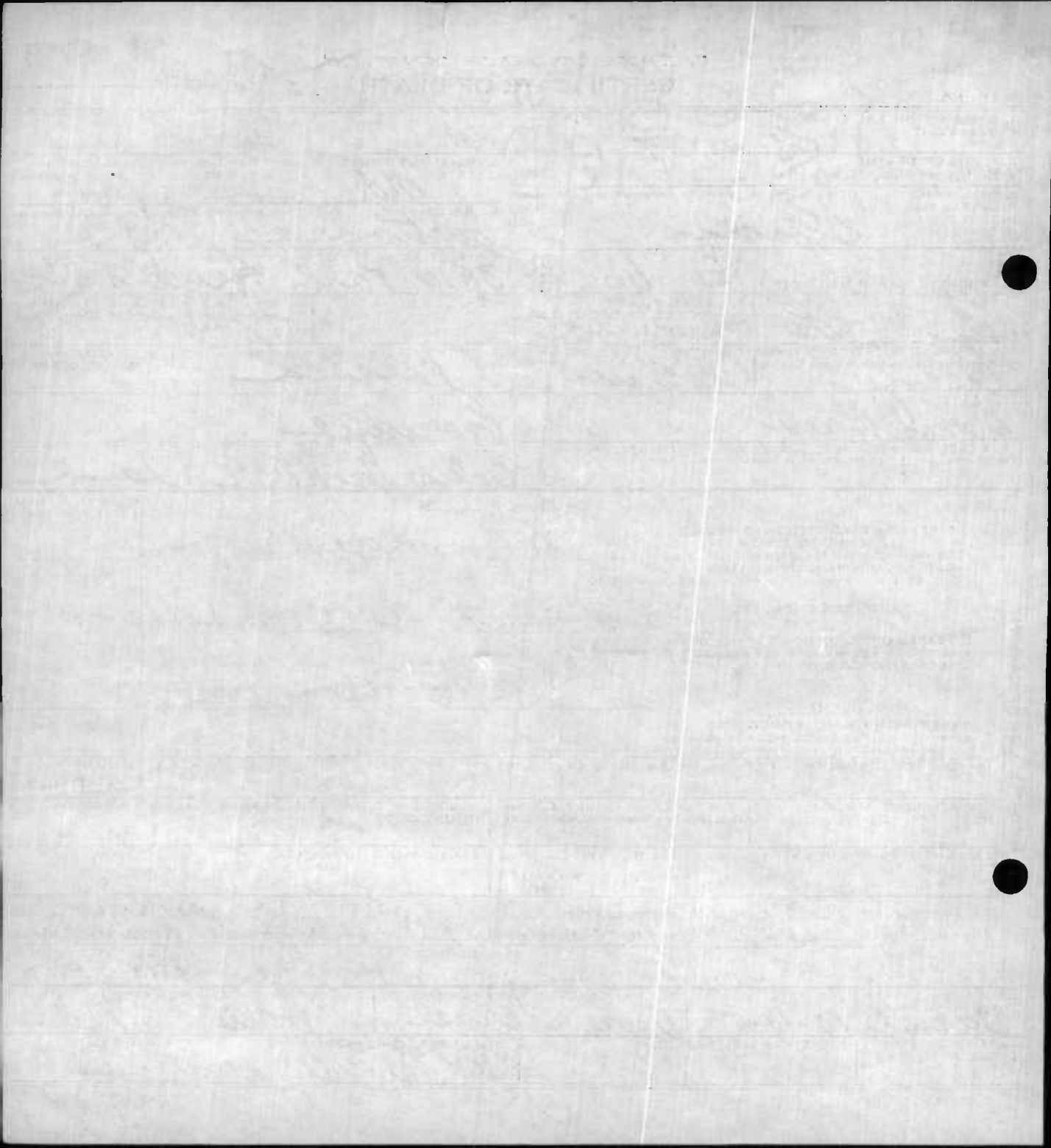
18. <b>42010</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarct</b>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Coronary thrombosis</b>	(B) <b>ASHD</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>10-13-50</b>	19B. MAJOR FINDINGS OF OPERATION <b>Coronary thrombosis</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>Accident</b>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Home</b>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>10-13-50</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Heart attack</b>

22. I hereby certify that I attended the deceased from **Oct 12, 1950**, to **Oct 12, 1950**, that I last saw the deceased alive on **Oct 12, 1950**, and that death occurred at **9:55 P. M.**, from the causes and on the date stated above.

23A. SIGNATURE **Frank Winter** M. D. 23B. ADDRESS **Sinai Hosp. Baltimore Md** 23C. DATE SIGNED **Oct 12 50**

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-13-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Chai Israel</b>	24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 13 1950</b>	REGISTRAR'S SIGNATURE <b>Jack Lewis</b>	25. FUNERAL DIRECTOR <b>Jack Lewis</b>	ADDRESS <b>2100 Eutan Pl</b>



165

50 8756

## BALTIMORE CITY HEALTH DEPARTMENT

50 8756

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Gertrude Abramowitz</i>			2. DATE OF DEATH <i>10/12/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore, Maryland</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>15-03</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <i>1808 Warwick Ave.</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH	9. AGE (in years last birthday) <i>69</i>	H Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Operator</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>New Clothing</i>		
11. BIRTHPLACE (State or foreign country) <i>Europe Russia</i>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Hyman Abramowitz</i>			14. MOTHER'S MAIDEN NAME <i>Mary Endelson</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Henry Abramowitz</i>			ADDRESS <i>1808 Warwick Ave.</i>		

18. <i>420.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) <i>Acute Coronary Thrombosis</i> DUE TO (B) <i>Arteriosclerotic Heart Disease</i> DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Nephritis</i>		

19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8/11/50*, 19\_\_, to *10/12/50*, 19\_\_, that I last saw the deceased alive on *10/12/50*, 19\_\_, and that death occurred at *8:45A.m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Marion C. Macapangan</i>	23B. ADDRESS <i>1213 Light Street</i>	23C. DATE SIGNED <i>10/12/50</i>
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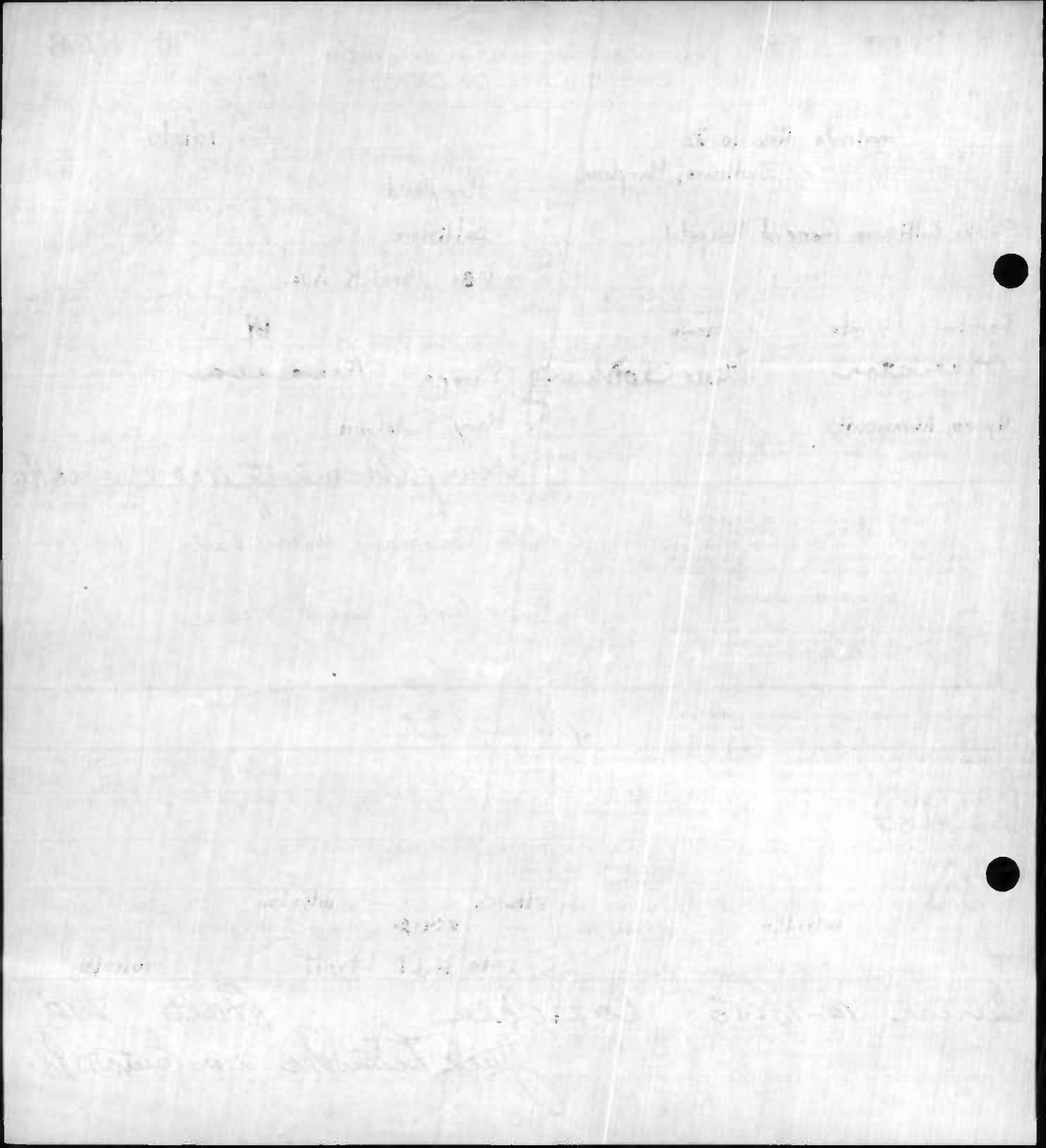
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <i>10-13-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Rosedale</i>	24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>
---	------------------------------	---	--

DATE RECEIVED BY LOCAL REGISTRAR <i>Oct 13 1950</i>	REGISTRAR'S SIGNATURE <i>James Lewis</i>	25. FUNERAL DIRECTOR <i>2100 Eutaw St</i>
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6904G

093d

MEDICAL CERTIFICATION





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

SARAH BERGER

2. DATE  
OF  
DEATH

10-12-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Md

B. COUNTY

15-11

5. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

3521 Helton Road

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

7. STREET ADDRESS (If rural, give location)

3521 Helton Road

Length of stay in Baltimore

40

Yrs.  
Mos.  
Days

8. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months: Days  
If Under 24 Hours Hours: Min.

Female White

Widow

70

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Hawes

14. MOTHER'S MAIDEN NAME

Tota

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Herman Berger - Same

18. 181X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) ...  
DUE TO

Acute Bladder

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ...  
DUE TO  
(C) ...

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 29, to Oct 12, 1950, that I last saw the deceased alive on Oct 12, 1950 and that death occurred at 8-17 m. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 13 1950

Jack Lewis

2100 Eutaw St

Gross  
not entered  
Ra 2447

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320<sup>50</sup> 8758BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8758

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

George Washington Butz

2. DATE

OF

DEATH

October 10, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's Hospital

Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Oct 24 1886

9. AGE (In years  
last birthday)

63

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR  
INDUSTRY

Balto. Transit Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Butz

14. MOTHER'S MAIDEN NAME

Elizabeth

15. WAS DECEASED EVER IN U. S. ARMED FORCES  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Charles Matthews 904 N. Maca

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Hypertensive Cardio Vascular  
Disease with decompensation  
and terminal pneumonia.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT ☐ NOT WHILE  
WORK AT WORK22. I hereby certify that I attended the deceased from 9/26/1950, to 10/10/1950, that I last saw the  
deceased alive on 10/10/1950, and that death occurred at 11:58 AM from the causes and on the date stated above.

23A. SIGNATURE

G. Paul Coffey Jr.

M. O.

23B. ADDRESS

1400 N. Caroline Street

23C. DATE SIGNED

10/10/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Oct 13/50

24C. NAME OF CEMETERY OR CREMATORY

Balto Cem

24D. LOCATION (City, town, or county)

Balto

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

George Washington Butz

25. FUNERAL DIRECTOR

ADDRESS

Belmont Funeral Home 2004 Orleans

VS 150

550 51

093d

MEDICAL CERTIFICATION

DEPARTMENT OF DEATH

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1900

REPORT

OF THE

COMMISSIONERS

OF THE

DEPARTMENT

OF DEATH

AND

HEALTH

FOR THE

YEAR

1899

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Joseph Aversa*

2. DATE  
OF  
DEATH

*10/11/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

*Franklin Square Hospital*

Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

*md. Baltimore*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore 27-17*

O. STREET ADDRESS (If rural, give location)

*5344 Winner Ave*

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*MARRIED*

8. DATE OF BIRTH

*Oct. 23, 1893*

9. AGE (In years  
last birthday)

*56*

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

*Clerk*

10B. KIND OF BUSINESS OR  
INDUSTRY

*Capital Fruit Pr. Co. (Valguarnara Italy)*

12. CITIZEN OF  
WHAT COUNTRY?

*U.S.*

13. FATHER'S NAME

*Giuseppe Aversa*

14. MOTHER'S MAIDEN NAME

*Filippina Guarnera*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

*no*

16. SOCIAL  
SECURITY NO.

*214-05-1083*

17. INFORMANT

ADDRESS

*Rose Aversa*

*5344 Winner Ave*

18. *153X*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) *Atelactosis*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) *Intestinal obstruction.*

DUE TO

(C) *Carcinoma descending colon*

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

*obstruction due to Carcinoma descending colon*

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from *Oct. 6*, 1950, to *Oct 11*, 1950, that I last saw the  
deceased alive on *Oct. 11*, 1950, and that death occurred at *5:05A.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Robert G. Chambers*

M. D.

23B. ADDRESS

*Franklin Square Hospital*

23C. DATE SIGNED

*10/11/50*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

*Burial*

24B. DATE

*Oct. 14 1950*

24C. NAME OF CEMETERY OR CREMATORY

*New Cathedral Cemetery*

24D. LOCATION (City, town, or county)

*4300 Old Frederick Rd*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*William G. Hill*

25. FUNERAL DIRECTOR

*Frank Weller Woe*

ADDRESS

*322 S. High St.*

STATE OF TEXAS

John T. Wilson



S-123

50 8760

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8760

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

KATHERINE E. SPEIGHTS

2. DATE OF DEATH  
Oct. 12, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

3919 Belview Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3919 Belview Ave.

Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Nov. 1878

9. AGE (In years last birthday)

71

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James McIntyre

14. MOTHER'S MAIDEN NAME

Mary McCourt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT ADDRESS  
Miss Mary McIntyre 1015 Cathedral St.

18. 170X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Carcinoma of Breast

1 yr

## ANTECEDENT CAUSES

DUE TO

(B)

Exhaustion

3 mo

DUE TO

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

June 10 1950

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of Breast - Left.

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 11, 1950, to Oct. 12, 1950, that I last saw the deceased alive on June 11, 1950, and that death occurred at 11:00 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Thos. C. Mahan

M. D.

23B. ADDRESS

Med. Arts Bldg

23C. DATE SIGNED

10-13-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/16/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National Cem

24D. LOCATION (City, town, or county) (State)

Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 13 1950

VS 150

050.0

MEDICAL CERTIFICATION

0073

1952

James J. [unclear]  
[unclear]

1952

1952

1952

1952

1952

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Anne Levin</b>			2. DATE OF DEATH <b>October 12, 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>901 Ramsey St</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
5. LENGTH OF STAY IN BALTIMORE <b>40 yrs</b>			D. STREET ADDRESS (If rural, give location) <b>901 Ramsey St</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec. 11, 1891</b>		9. AGE (In years last birthday) <b>58</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>Russia</b>
13. FATHER'S NAME <b>Philip Levin</b>			14. MOTHER'S MAIDEN NAME <b>Sarah ?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Morris Levin 901 Ramsey St</b>		

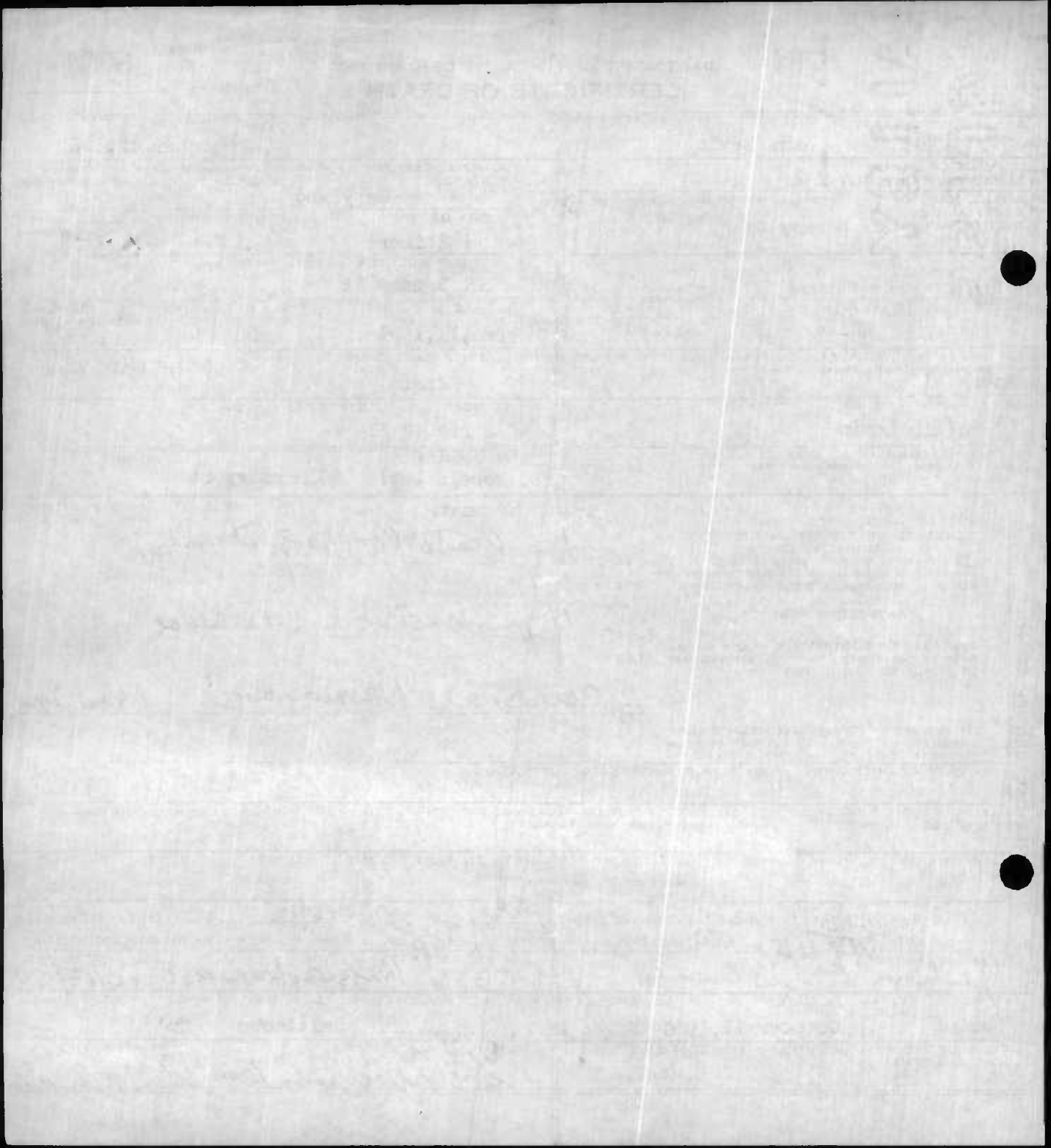
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <b>My Acute Coronary Thrombosis</b> DUE TO (B) <b>Hypertensive C. V. Disease</b> DUE TO <b>Cerebral Hemorrhage</b>	INTERVAL BETWEEN ONSET AND DEATH  <b>about 7 mos.</b>
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19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **July 1950** to **10/12, 1950**, that I last saw the deceased alive on **10/15, 1950** and that death occurred at **9 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>J. C. Gluck</b>		23B. ADDRESS <b>5356 Reisterstown Rd</b>		23C. DATE SIGNED <b>10/13/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>October 13, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mogen Abraham Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	

DATE RECEIVED BY LOCAL REGISTRAR <b>10/13/1950</b>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR <b>Sol Swinson &amp; Bros W North Ave</b>	
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363

50 8762

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 36-98

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William Henry Stewart

2. DATE  
OF  
DEATH

10-10-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

1139 N. Stricker St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

16-02

D. STREET ADDRESS (If rural, give location)

1139 N. Stricker Street

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months Days  
If Under 24 Hours  
Hours Min.

Male

Negro

Married

7-30-76

74

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

Stevedore

11. BIRTHPLACE (State or foreign country)

Charles G. Md

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

217-05-5227

17. INFORMANT

ADDRESS

Hattie Stewart 1139 Stricker St.

18. 592X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Myocarditis

DUE TO

Unknown

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Chronic Nephritis

DUE TO

Unknown

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 6-15, 1950, to 10-10, 1950, that I last saw the  
deceased alive on 10-10, 1950, and that death occurred at 2:30 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Frank A. Saunders

M. D.

1029 N. Stricker St.

10-12-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

10-12-50

Arbutus

Baltimore, Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 13 1950

Frederick J. Williams

Charles R. Law 802 Madison Ave.

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 8763

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>ERNEST ROHRMAN</b>			2. DATE OF DEATH <b>OCT 12, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>DSL. 6</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 3-02</b>		
Length of stay in Baltimore <b>53</b> Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>846 S. BOND ST.</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDDED, DIVORCED (Specify) <b>WIDDED</b>	8. DATE OF BIRTH <b>12-4-96</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Cat Drive.</b>	11. BIRTHPLACE (State or foreign country) <b>Balto. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Ernest Rohrman</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth American</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-03-5151</b>	17. INFORMANT <b>JOHNS HOPKINS HOSPITAL</b> ADDRESS _____		

18. <b>442X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) <b>Hypertensive Cardio - Vascular Disease</b> DUE TO (B) <b>Arteriosclerosis</b> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs. 3-4 mo.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		

**II**  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <b>2</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>10-7</b> 19 <b>50</b> , to <b>10-12</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>10-12</b> , 19 <b>50</b> , and that death occurred at <b>5:55</b> P.M., from the causes and on the date stated above.					
23A. SIGNATURE <b>David J. Peters</b>		23B. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		23C. DATE SIGNED <b>10-13-50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>16, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Park</b>	24D. LOCATION (City, town, or county) (State) <b>Harford Rd</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 13 1950</b>		REGISTRAR'S SIGNATURE <b>William H. Williams</b>	25. FUNERAL DIRECTOR <b>Joseph Fargnoli</b> ADDRESS <b>2013 Greenmount Ave</b>

**68254**

**131a**

MEDICAL CERTIFICATION

Page 11 of 11  
11/11/11

11/11/11

11/11/11  
11/11/11  
11/11/11

350 50 8764

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 8764

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>FLORA E. STEIN</b>		2. DATE OF DEATH <b>10-13-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Mt Carmel Home</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE <b>Md</b> COUNTY <b>15-13</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>2476 Shirley Ave</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>2476 Shirley Ave</b>		E. Length of stay in Baltimore <b>42</b> Yrs. <b>Mo.</b> <b>Days</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>10-2-1862</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sailor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	
11. BIRTHPLACE (State or foreign country) <b>Lith</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mendel</b>		14. MOTHER'S MAIDEN NAME <b>Hannah</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Etzel Karsch - 6000 Edw St</b>		ADDRESS	

18. <b>490X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Relapsing Pneumonia</b> DUE TO (A) <b>Relapsing Pneumonia</b> (B) <b>Articulatio</b> DUE TO (C) <b>Articulatio</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>?</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Sept 8, 1950**, to **Oct 13, 1950**, that I last saw the deceased alive on **Oct 12, 1950**, and that death occurred at **3:00 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>Reuben K. Kellum</b>		23B. ADDRESS <b>3700 Park Heights Ln</b>		23C. DATE SIGNED <b>Oct 13 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		24B. DATE <b>10-13-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>London Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		24E. FUNERAL DIRECTOR <b>Jack Lewis</b>		24F. ADDRESS <b>2100 Eutaw Pl</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 13 1950</b>		REGISTRAR'S SIGNATURE <b>Washington Williams, Jr.</b>		24G. FUNERAL DIRECTOR <b>Jack Lewis</b>	

59046

108.0

MEDICAL CERTIFICATION

Kolman  
3700 Park Hgts

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>George BERENDS</b>			2. DATE OF DEATH <b>Oct 11, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>OSL. 6</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>JRS HOPKINS HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 26-09</b>		
Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>818 S. FABLEY ST.</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10-20-10</b>	9. AGE (In years last birthday) <b>39</b>	If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Maritime Comm.</b>		
11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>FREDERICK BERENDS</b>			14. MOTHER'S MAIDEN NAME <b>Louisa Mahr.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO NONE</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		

**CAUSE OF DEATH**

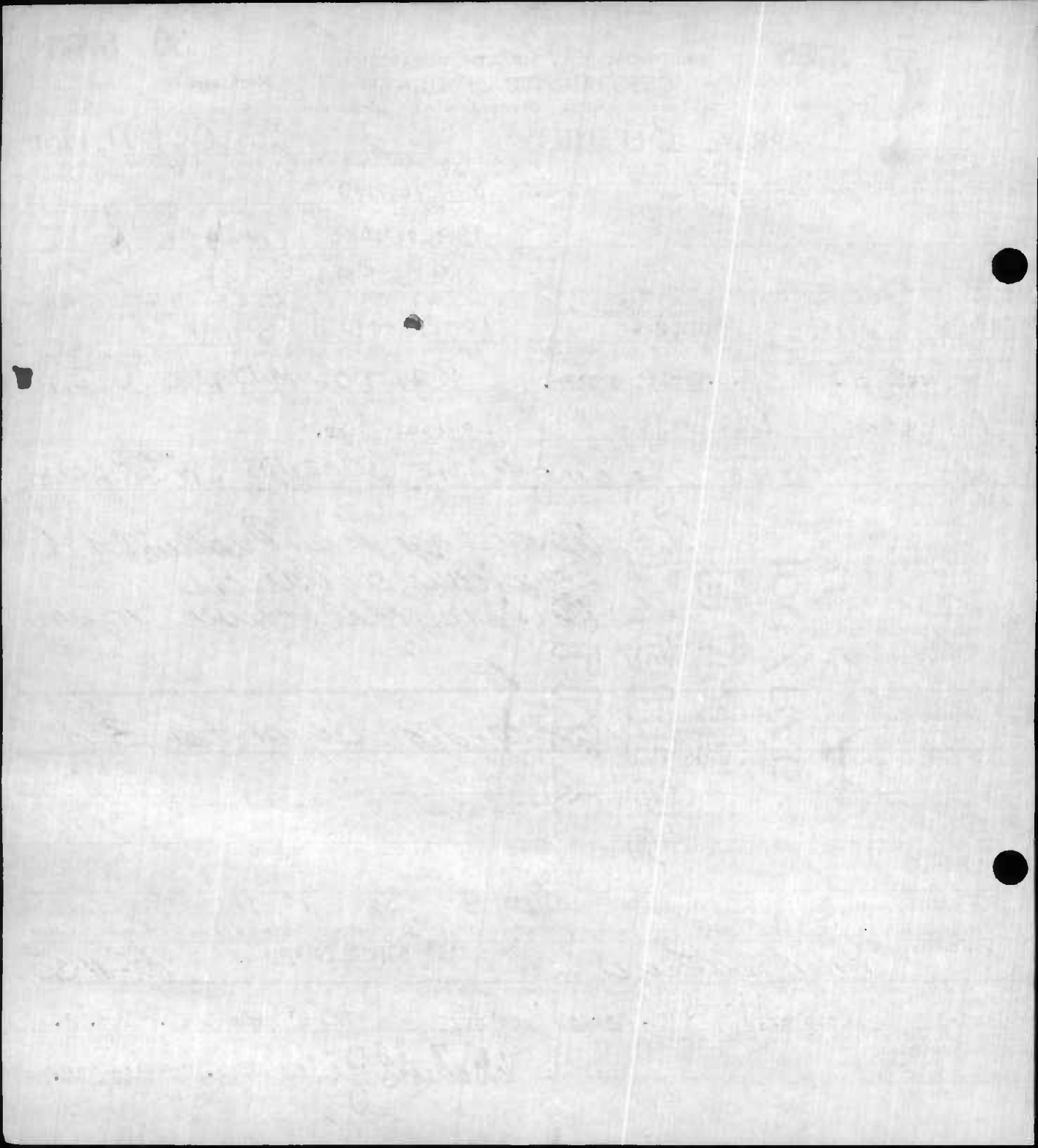
18. <b>581.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH   10 years 3 d.
(A) <b>Hemorrhage from Ruptured 4 d. Esophageal Varices</b> DUE TO <b>Cirrhosis of the Liver</b>	
(B) <b>Myocardial Infarction</b> DUE TO <b>3 d.</b>	
(C) _____	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> ND <input type="checkbox"/>	
21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **10-9**, 19**50**, to **10-11**, 19**50**, that I last saw the deceased alive on **10-11**, 19**50**, and that death occurred at **4:30 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>David J. Glick</b>		23B. ADDRESS <b>JRS HOPKINS HOSPITAL</b>		23C. DATE SIGNED <b>10-11-50</b>	
---	--	---	--	-------------------------------------	--

24A. BURIAL, CREMA- TION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>October, 14, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>5720 O'Donnell St. Balto. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>10-13-50</b>		REGISTRAR'S SIGNATURE <b>Charles S. Geiler</b>		25. FUNERAL DIRECTOR <b>Charles S. Geiler</b>		ADDRESS <b>901 S. Conkling St.</b>	





BALTIMORE CITY HEALTH DEPARTMENT

**CERTIFICATE OF DEATH**

Registered No. 8766

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) Mary Mizurak MIZURAK

2. DATE OF DEATH October 11, 1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland  
B. COUNTY Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION Hamblin Square Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

Length of stay in Baltimore  
Yrs. 0  
Mos. 0  
Days 0

D. STREET ADDRESS (If rural, give location) 1605 Cornington St.

5. SEX Female  
6. COLOR OR RACE White  
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Nov. 15, 1907  
9. AGE (In years last birthday) 42  
If Under 1 Year: Months: Days  
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife  
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) New Jersey  
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Andrew Sariski

14. MOTHER'S MAIDEN NAME Anna Karus chak

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.  
17. INFORMANT ADDRESS ☒

18. 410X  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

(A) Congestive heart failure  
DUE TO

not known

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Mitral stenosis  
DUE TO

not known

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Rheumatic heart disease  
None

not known

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 2, 1950 to Oct 11, 1950 that I last saw the deceased alive on Oct 11, 1950, and that death occurred at 4:15 pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

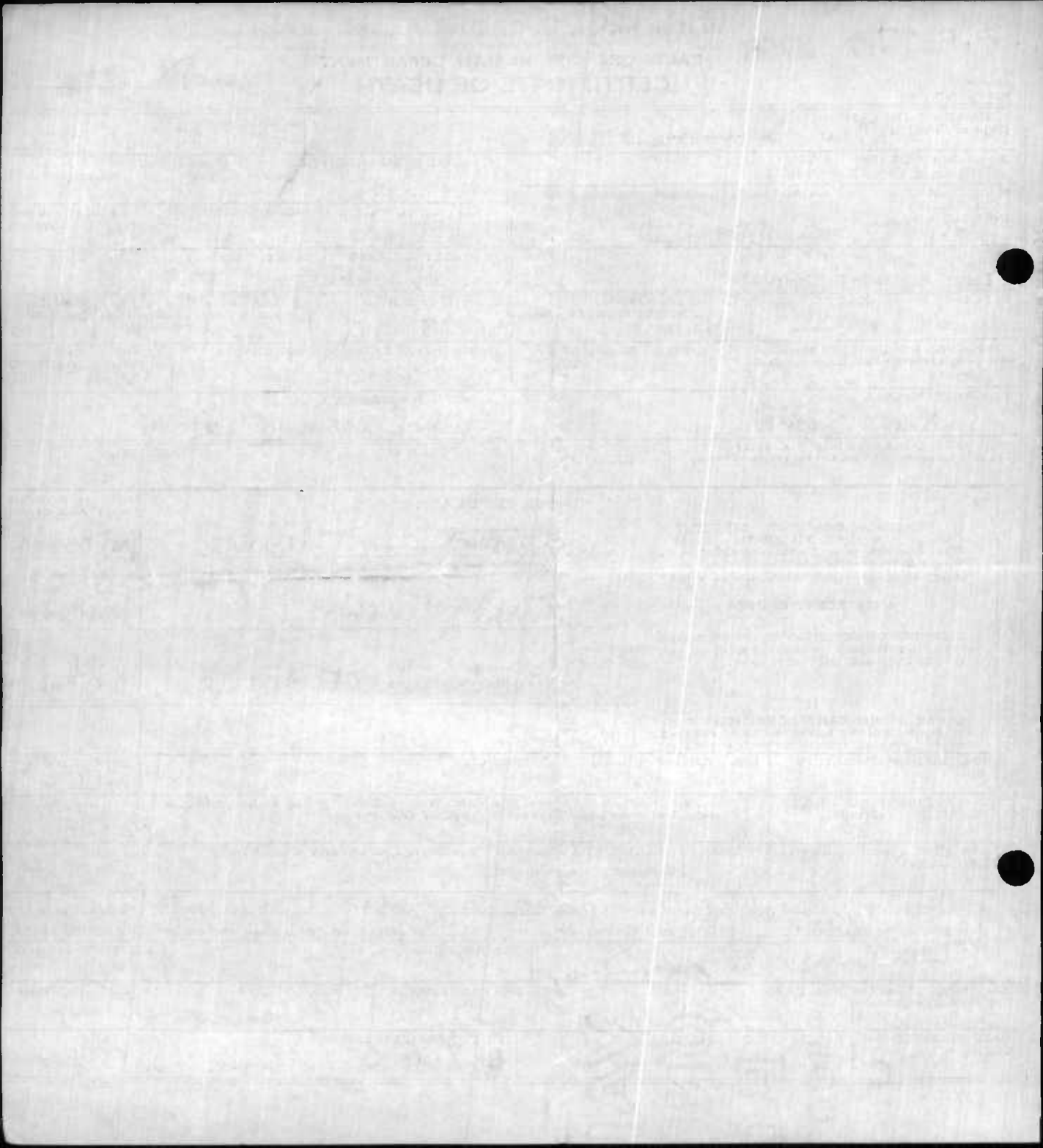
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



B-260

50

8767

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50

8767

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

George C. Becker

2. DATE  
OF  
DEATH

10-12-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Maryland General Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

27-34

D. STREET ADDRESS (If rural, give location)

5404 Belair Rd. #6

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

November 15, 1875

9. AGE (In years  
last birthday)

74

If Under 1 Year  
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Gardner

10B. KIND OF BUSINESS OR  
INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Frederick Becker

14. MOTHER'S MAIDEN NAME

Anna B. Krieger

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Anna Becker 2615 Hiewelyn #13

18. 442X

CAUSE OF DEATH (State)

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) uremia

DUE TO

2 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Chronic glomerulonephritis

DUE TO

(C) Arteriosclerotic cardio-vascular  
renal diseaseOTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Benign prostatic hypertrophy

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from October 1, 1950, to October 12, 1950, that I last saw the  
deceased alive on October 12, 1950, and that death occurred at 3:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 13 1950

9308A

131a

MEDICAL CERTIFICATION



K-621

50

8768

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50

8768

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Constatine

KORZYBSKI

2. DATE  
OF  
DEATH

Oct. 12 - 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Balto. City*

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

Md.

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

3802 Pennington ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Balto. 25-05

D. STREET ADDRESS (If rural, give location)

3802 Pennington ave

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec. 15 - 1909

9. AGE (In years,  
last birthday)

40 41

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Maintenance man

10B. KIND OF BUSINESS OR  
INDUSTRY

Tide water &amp; Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Carimer

Korzybski

14. MOTHER'S MAIDEN NAME

Bertha Korzybska

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

212-07-4216

17. INFORMANT

Agnes Korzybski

ADDRESS

3802 Pennington ave

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Coronary Heart Disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

mild hypertension

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from July 25, 1950, to Oct 12, 1950, that I last saw the  
deceased alive on 10/12, 1950, and that death occurred at 10 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

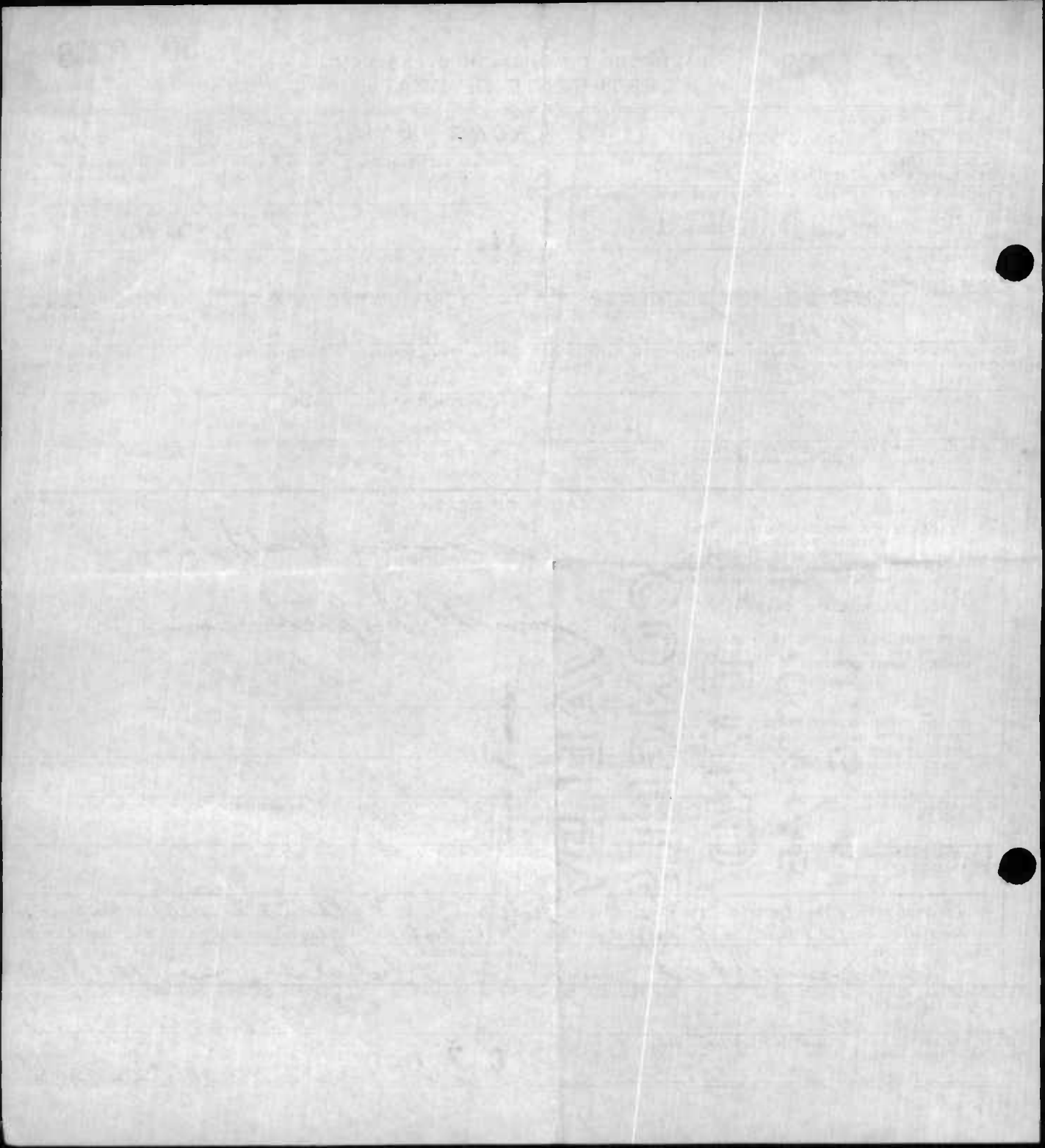
ADDRESS

OCT 13 1950

55466

094a

MEDICAL CERTIFICATION





K-520

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

50 8769

50 8769

1. NAME OF DECEASED  
(Type or Print)

MURRILL KING

2. DATE  
OF  
DEATH

Oct. 12, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

John Hopkins Hospital, D.O.A.

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Baltimore

8-07

D. STREET ADDRESS (If rural, give location)

2019 E. Preston Street

Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Jan. 3, 1888

9. AGE (In years

last birthday)

62

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

BRAKEMAN

10B. KIND OF BUSINESS OR INDUSTRY

RAILROAD

11. BIRTHPLACE (State or foreign country)

Beavertown, Penna

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John King

14. MOTHER'S MAIDEN NAME

Elizabeth Lehl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Decker &amp; Lunsel Home, Marysville, Pa.

18. 422.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Arteriosclerotic Cardiovascular Disease

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held a Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

John R. Davis

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒

23c. DATE SIGNED

10/13/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

10/13/50

24C. NAME OF CEMETERY OR CREMATORY

Chestnut Grove

24D. LOCATION (City, town, or county)

Marysville, Penna

(State)

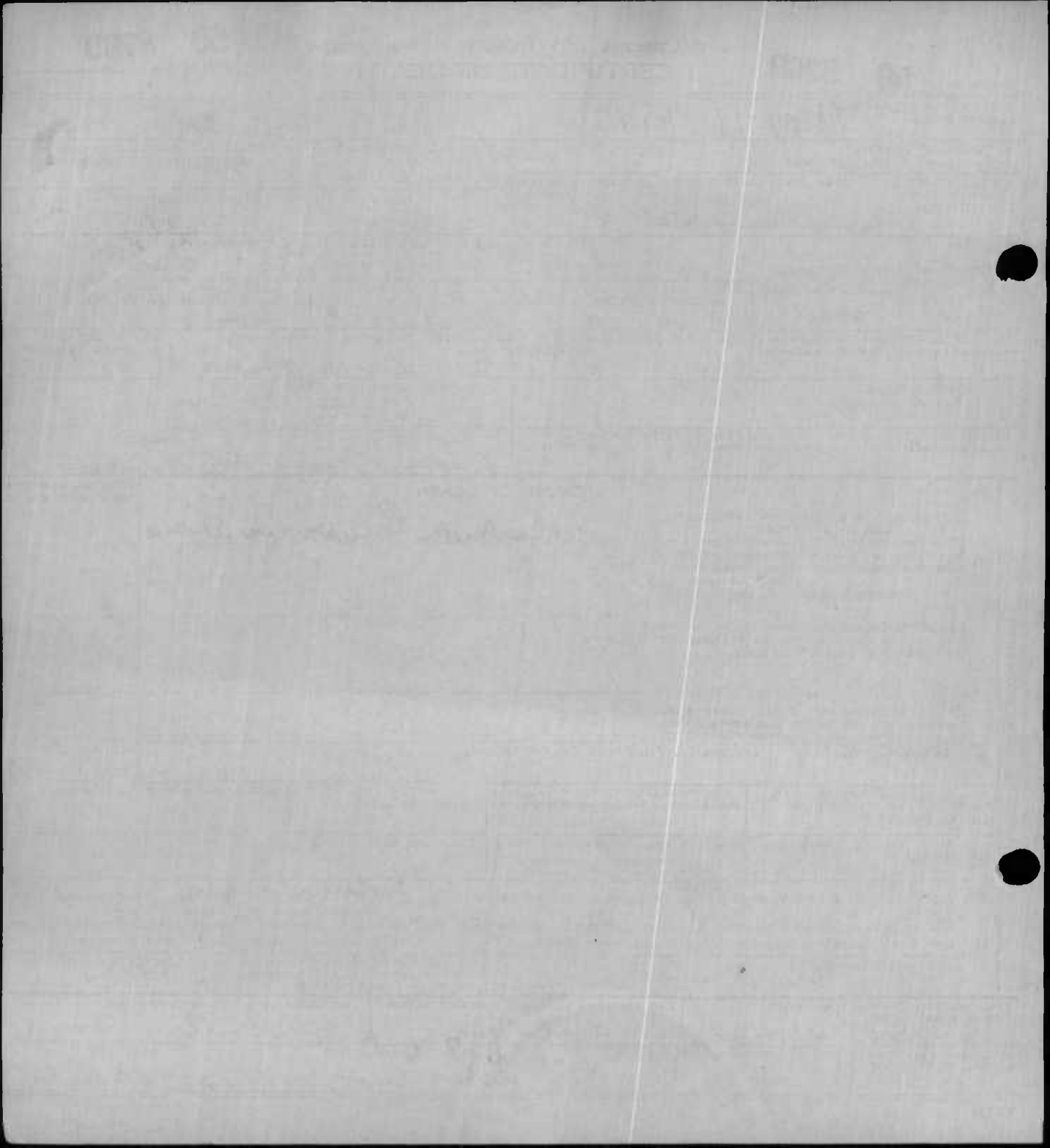
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

F. FUNERAL DIRECTOR

ADDRESS

Hon. Cook, Inc. 1217 St. Paul St.



W-430  
50 8770BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8770

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Mary A. Wildt</i>		2. DATE OF DEATH <i>10/12/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md</i> B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <i>3004 Lock Raven Rd.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto</i> 9-04	
6. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>3004 Lock Raven Rd.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>9/11/1913</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Candy Packer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Vonierff Drayage Co</i>	9. AGE (In years last birthday) <i>37</i>
11. BIRTHPLACE (State or foreign country) <i>Balto Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Charles Wildt</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Miller</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Chas. Wildt</i>		ADDRESS <i>3004 Lock Raven Rd</i>	

18. <i>421.4</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>acute myocardial failure</i> DUE TO (B) <i>Cordain Valentin disease</i> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <i>10/16/50</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

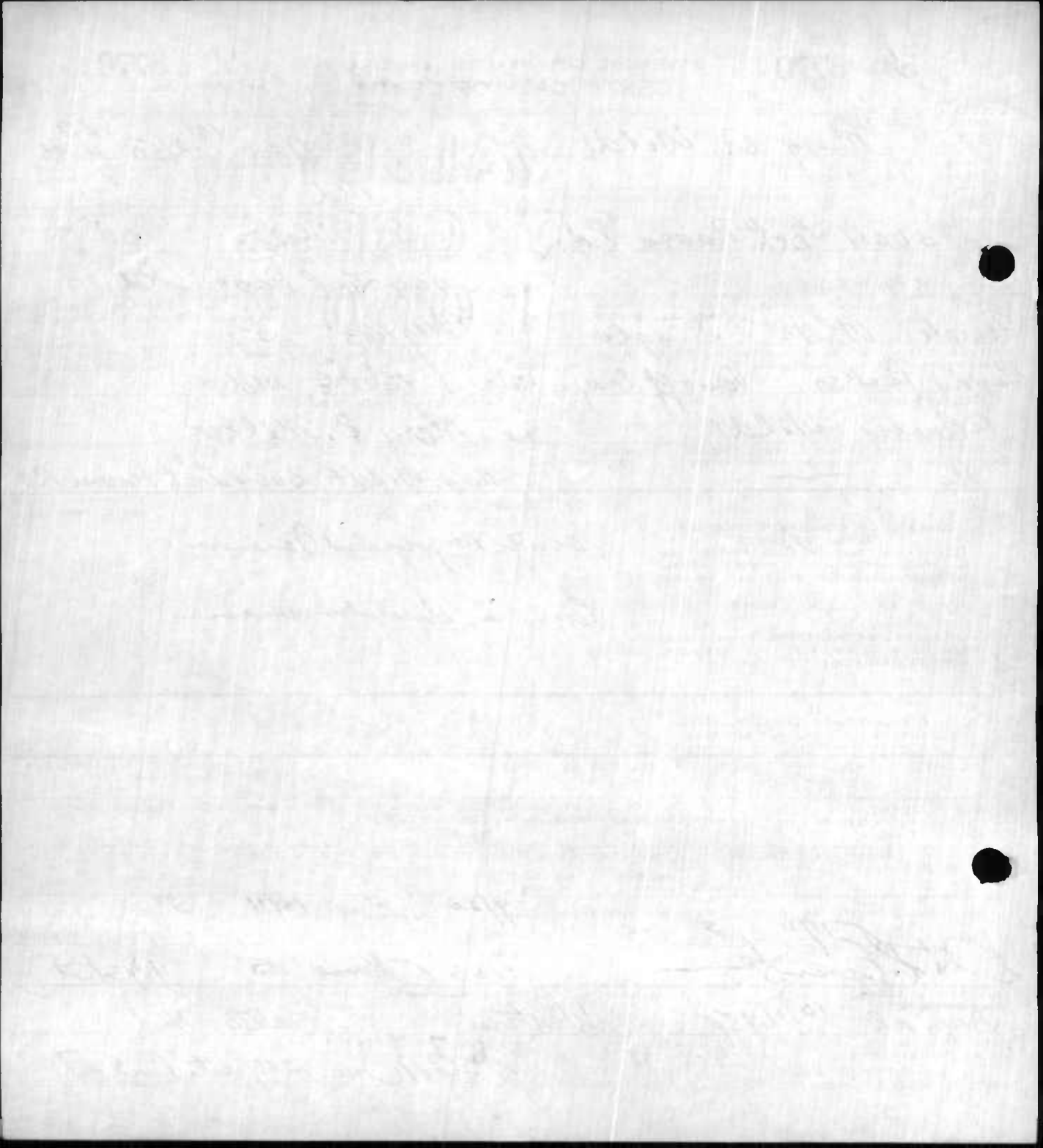
22. I hereby certify that I attended the deceased from *9/20*, 19*50*, to *10/11*, 19*50*, that I last saw the deceased alive on *10/11*, 19*50*, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23A. SIGNATURE <i>[Signature]</i>	23B. ADDRESS <i>1123 5th Ave SE</i>	23C. DATE SIGNED <i>10/13/50</i>
--------------------------------------	--	-------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>10/16/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Western</i>	24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
--	------------------------------	--	--

DATE RECEIVED BY LOCAL REGISTRAR <i>10/13/50</i>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR <i>W. Cook Inc.</i>	ADDRESS <i>1217 St. Paul St.</i>
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VS. 150  
H. D. FRANKLIN 690 45 092d



5-162

50 8771

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 8771

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

CATHERINE SPRAGUE

2. DATE  
OF  
DEATH

10/12/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

2620 Maryland Ave

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Crawford Retreat

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto

Md

12-07

D. STREET ADDRESS (If rural, give location)

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Aug 15<sup>th</sup>

9. AGE (In years last birthday)

73

H Under 1 Year

Months: Days

H Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Lumber Packer

10B. KIND OF BUSINESS OR INDUSTRY

Md. Biscuit Co

11. BIRTHPLACE (State or foreign country)

Balto Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Harry C. Blaney

14. MOTHER'S MAIDEN NAME

Catherine Larmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Naomi Archer 14 W. Cross St

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis

DUE TO

months?

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Cerebral Arterio-sclerosis

months?

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

None.

None.

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

INJURY

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Aug. 25, 1950, to Oct. 12, 1950, that I last saw the deceased alive on Oct. 12, 1950, and that death occurred at 9:45 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Frank W. Gorden

M. D.

23B. ADDRESS

2701 N. Calvert St.

23C. DATE SIGNED

Oct. 12, 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/16/50

24C. NAME OF CEMETERY OR CREMATORY

Mt Olivet

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 13 1950

[Signature]

[Signature]

127 St Paul St

VS 150

69044

093d

MEDICAL CERTIFICATION

CATHERINE OPERA



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Catherine Culham*

2. DATE  
OF  
DEATH

*Oct. 11, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

*JONES HOPKINS HOSPITAL*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years  
last birthday)

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

*JONES HOPKINS HOSPITAL*

18. *201X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

*Hodgkin's Disease*

*14 yrs.*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from *9/11* *1950*, to *10/11* *1950*, that I last saw the deceased alive on *10/11* *1950*, and that death occurred at *9:12* *am.*, from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

*Charles M. Linn Jr.*

*JONES HOPKINS HOSPITAL*

*10/11/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

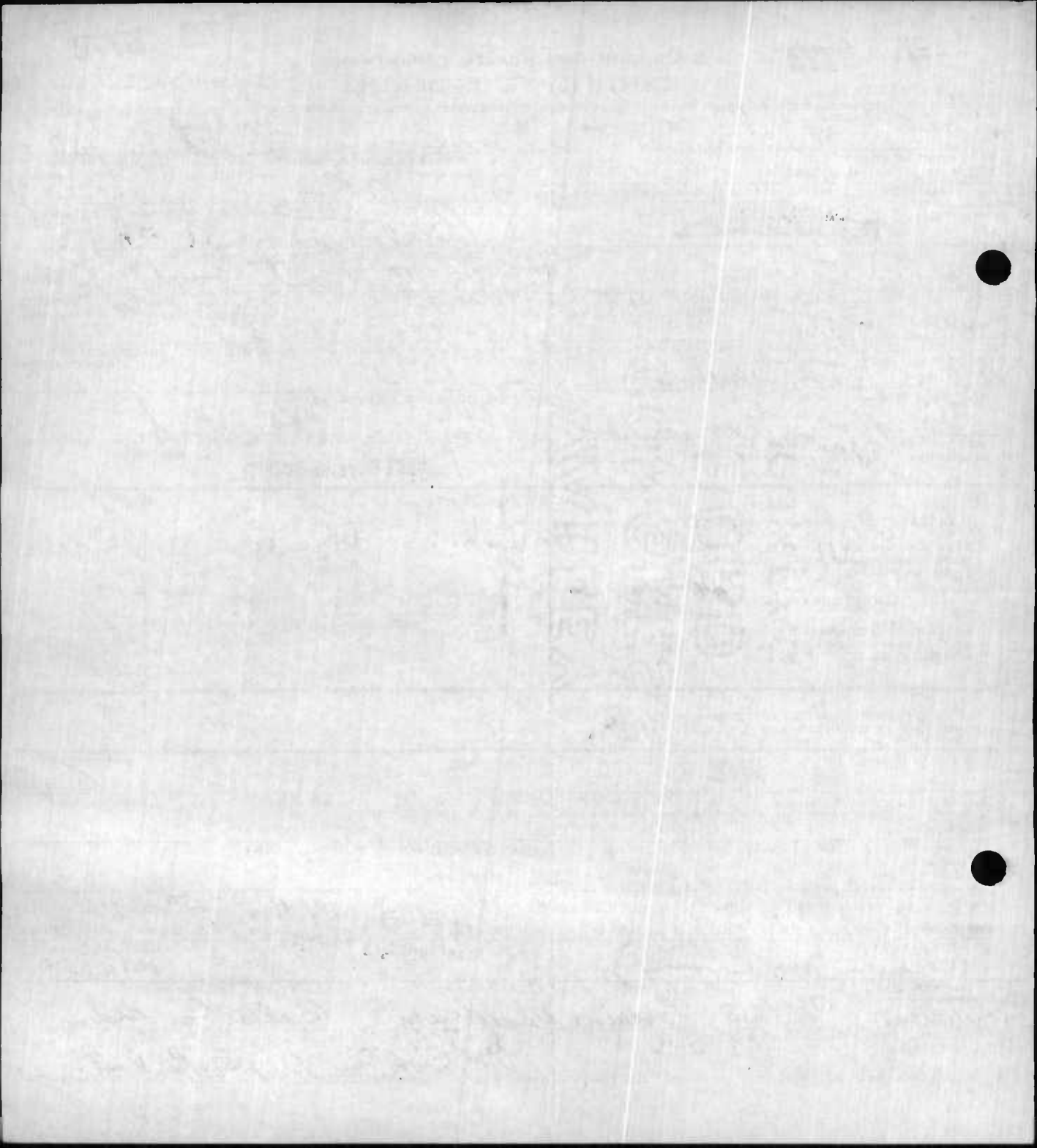
*Interment*

*10/14/50*

*Lorraine Mausoleum*

*Balto. Co. Md.*

*Dr. Cook, Inc. 1217 St. Paul St.*



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Minna D. Osborne

2. DATE  
OF  
DEATH

Oct. 11, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2902 Bayonne Avenue

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

27-06

D. STREET ADDRESS (If rural, give location)

2902 Bayonne Avenue

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Jan. 1, 1891

9. AGE (In years last birthday)

59

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Frederick W. Lollmann

14. MOTHER'S MAIDEN NAME

Dorothy H. M. Lampe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Edward Lollmann, 2902 Bayonne Avenue

18.

151X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

*Carcinoma tons*

DUE TO

*Ca of Stomach*

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

*Jan 1950*

*1924*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

*Jan 1950*

19B. MAJOR FINDINGS OF OPERATION

*Ca of Stomach Liver etc*

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER- Lying ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

22. I hereby certify that I attended the deceased from *Jan 1949* to *Oct 10, 1950*, that I last saw the deceased alive on *10/11*, 19*50*, and that death occurred at *8:30 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Walter E. Kargis*

23B. ADDRESS

*4331 Harford Rd*

23C. DATE SIGNED

*10/12/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

10/14/50

24C. NAME OF CEMETERY OR CREMATORY

St. Mathew's

24D. LOCATION (City, town, or county)

Baltimore,

Maryland

DATE RECEIVED BY LOCAL REGISTRAR

OCT 13 1950

REGISTRAR'S SIGNATURE

*Thurman J. Williams*

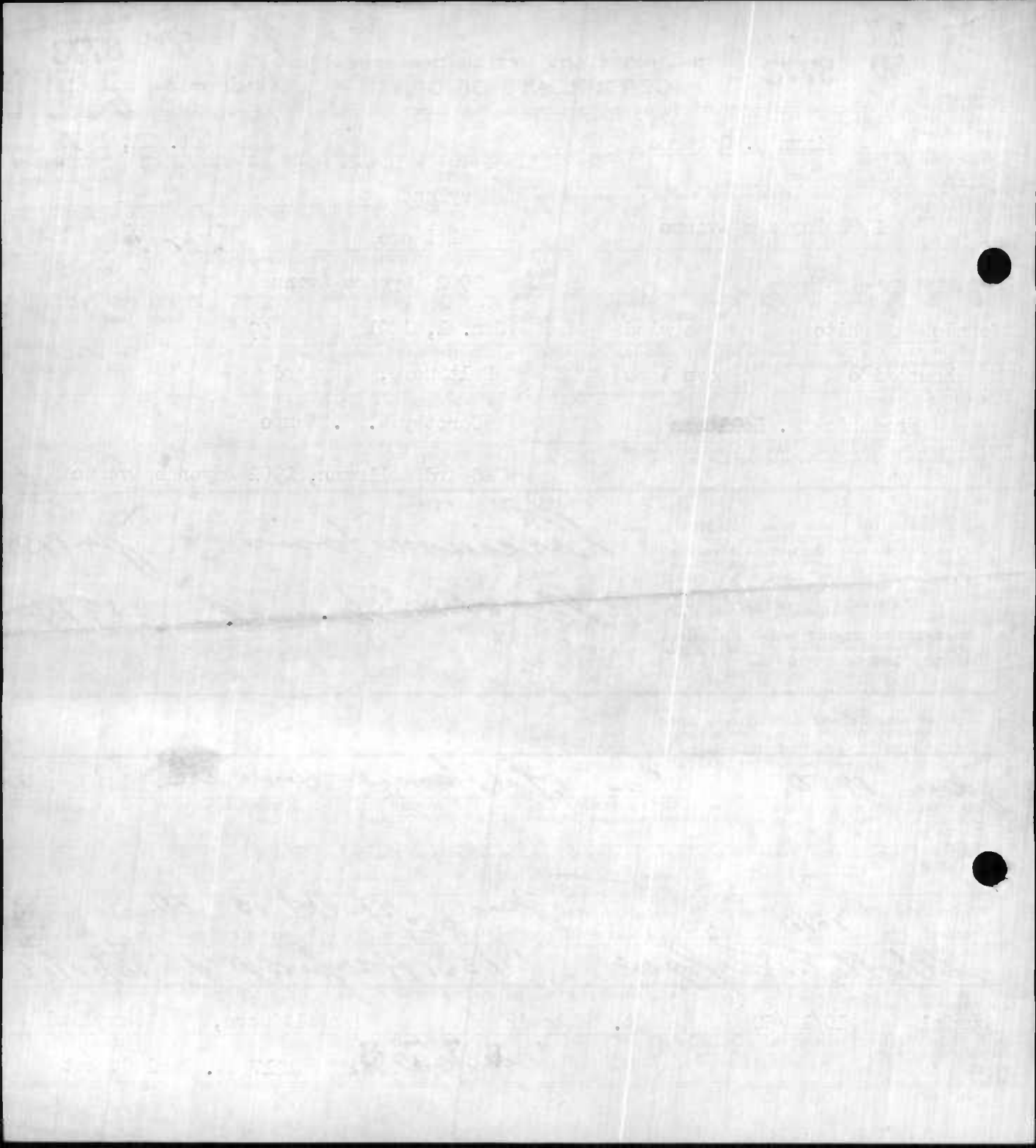
25. FUNERAL DIRECTOR

*Wm. Cook, Inc.*

ADDRESS

1217 St. Paul Street

MEDICAL CERTIFICATION



B-200

50 8774

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8774

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Franciszka Frances Buczek

2. DATE  
OF  
DEATH

Oct 11-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2412 Hudson Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore-24 1-04

D. STREET ADDRESS (If rural, give location)

2412 Hudson Street

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Nov

1883

9. AGE (In years last birthday)

76

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

John Hezek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

James Buczek 2412 Hudson Street

18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

(A) Hypertension Cordis - Vascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22 I hereby certify that I attended the deceased from Oct. 7, 1950, to Oct. 11, 1950, that I last saw the deceased alive on Oct. 10, 1950, and that death occurred at 1:39 A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct 14, 1950

24C. NAME OF CEMETERY

St. Stanislaus

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

George A. Weber 200 S. Ann





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**George C. Walker**

2. DATE  
OF  
DEATH

**10/12/50**

3. PLACE OF DEATH:

A. Baltimore City, Maryland **1311 N. Broadway**

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

**Md.**

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

**Balto.**

D. STREET ADDRESS (If rural, give location)

**1311 N. Broadway**

5. SEX

**M**

6. COLOR OR RACE

**W**

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

**Married**

8. DATE OF BIRTH

**Aug. 22. 1890**

9. AGE (In years  
last birthday)

**60**

10 Under 1 Year  
Months Days

11 Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

**Produce dealer**

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Balto. Md.**

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

**George S. Walker**

14. MOTHER'S MAIDEN NAME

**Annie Foy**

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT ADDRESS  
**Mrs. Mary B. Walker 1311 N. Broadway**

18. **331X**

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

**Cerebral hemorrhage**

**1 day**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

**arteriosclerosis generalized**

**-?**

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Oct 11, 1950** to **Oct 12, 1950** that I last saw the  
deceased alive on **Oct 12, 1950** and that death occurred at **11:15 A.M.** from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

**Louis F. Klimes**

M. D.

**2623 S. Mount Airy St.**

**10/13/50**

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

**Burial**

24B. DATE

**10/16/50**

24C. NAME OF CEMETERY OR CREMATORY

**Baltimore**

24D. LOCATION (City, town, or county)

**Balto. Md.**

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**Oct 13 1950**

**Director of Health, Md.**

**E. I. Fanning & Son 1938 E. Lafayette Av**

CERTIFICATE OF DEATH

EASTMAN

1915

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

NAME OF DECEASED

NAME OF NEXT OF KIN

NAME OF PHYSICIAN

NAME OF BURIAL PLACE

NAME OF MINISTER

NAME OF WITNESSES

NAME OF REGISTRAR

NAME OF CLERK

NAME OF JUDGE

NAME OF SHERIFF

W-416

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8776

BIRTH NO. 50 8776

1. NAME OF DECEASED (Type or Print) <b>Mary A. Wolferman</b>		2. DATE OF DEATH <b>10-13-50</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b> <b>Baltimore</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>303 S. Baylis Street</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore, Md. 26-08</b>	
D. LENGTH OF STAY IN BALTIMORE <b>Life</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>303 S. Baylis Street</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>9-17-90</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>60</b>
13. FATHER'S NAME <b>Thomas Evans</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
17. INFORMANT <b>Frank Wolferman</b>		ADDRESS <b>303 S. Baylis Street</b>	

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Antenatal Infection both feet</b> DUE TO	CAUSE OF DEATH <b>Antenatal Infection both feet</b> DUE TO <b>Hypertensive Heart Disease</b> <b>Generalized Arteriosclerosis</b>	INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>4 yrs</b> <b>8 yrs</b>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>June</b> , 19 <b>50</b> , to <b>Oct</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>Oct. 12</b> , 19 <b>50</b> , and that death occurred at <b>5:25 A.</b> m., from the causes and on the date stated above.		
23A. SIGNATURE <b>Clarence W. L. G. S. S.</b>	23B. ADDRESS <b>3023 Eastern Ave.</b>	23C. DATE SIGNED <b>10/13/50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-16-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 13 1950</b>	REGISTRAR'S SIGNATURE <b>William H. Williams</b>	25. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler</b>	ADDRESS <b>403 S. Wolfe Street</b>

10-13-70

10-13-70

10-13-70

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10-13-70

10-13-70

10-13-70

10-13-70

10-13-70

10-13-70

A-352

50 8777

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 8777

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas Adams

2. DATE  
OF  
DEATH

Oct. 12, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

Balto.

b. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

820 E. Pratt St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

a. STATE Md.

b. COUNTY

c. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore, Maryland. 3-02

d. STREET ADDRESS (If rural, give location)

820 E. Pratt Street

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDDED, DIVORCED (Specify)  
Married10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Helper

10b. KIND OF BUSINESS OR  
INDUSTRY

Nat. Brewery

13. FATHER'S NAME

Charles Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

Aug. 30-98

9. AGE (In years  
last birthday)

52

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?  
USA

14. MOTHER'S MAIDEN NAME

Bertha Backus

17. INFORMANT

Elizabeth Adams

ADDRESS

6717 Danville Ave

18. 002X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary Tuberculosis

5 mos.

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21b. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23a. SIGNATURE

Wm. H. Kammer, J.

M.D.

23b. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....23c. DATE SIGNED  
Oct. 12, 195024a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24b. DATE

10-16-50

24c. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24d. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

403 S. Wolfe Street

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Lillie Mae Hughes</b>		2. DATE OF DEATH <b>Oct. 10, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto. City</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
5. FULL NAME OF (If not in hospital or institution, give street address or location) <b>1004 East Monumehnt St</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <b>Baltimore City 10-02</b>	
6. Length of stay in Baltimore <b>30 yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>1004 East Monument Street</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>4/10/1910</b>
9. AGE (In years last birthday) <b>40</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundress</b>	
11. BIRTHPLACE (State or foreign country) <b>Gloster Co. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hughes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Frank Carroll</b>		ADDRESS <b>1004 E. Monument St</b>	

18. <b>442X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <b>Acute Intestinal Hemiplegia</b> DUE TO (B) <b>Cardio-Cerebral Vascular Disease</b> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b> <b>1 wk.</b>
---	--	--

19A. DATE OF OPERATION <b>10-10-50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Aug. 28, 1950** to **Oct. 10, 1950** that I last saw the deceased alive on **10-10-50**, 19**50**, and that death occurred at **1:20 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE **Wm. L. Roy Denny** M. D. **1420 E. Chase St** 23C. DATE SIGNED **10-12-50**

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/14/1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Brooklyn Md</b>
---	-----------------------------	--	--

DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 13 1950</b>	REGISTRAR'S SIGNATURE <b>Wm. L. Roy Denny</b>	FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson</b>	ADDRESS <b>1000 Brantly Ave</b>
---	---	---	---------------------------------

**643 8C**

**131a**

MEDICAL CERTIFICATION

# WATKINS

Dear Sir: I have the honor to acknowledge the receipt of your letter of the 10th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Yours faithfully,  
J. W. Watkins

Enclosed for you are the following documents:

1. A copy of the report of the committee on the subject of the proposed amendment to the constitution of the State of New York.

2. A copy of the report of the committee on the subject of the proposed amendment to the constitution of the State of New York.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Daniel A. March*

(Melnechuk)

2. DATE  
OF  
DEATH

*10-12-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*1240 N. Patomac Street*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

*Maryland*

B. COUNTY

C. CITY OR TOWN

*Baltimore*

*8-03*

D. STREET ADDRESS (If rural, give location)

*1240 N. Patomac Street*

Length of stay in Baltimore

*35 days*

5. SEX

*M*

6. COLOR OR RACE

*W*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Married*

8. DATE OF BIRTH

*Dec. 25 1898*

9. AGE (in years last birthday)

*51*

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Hydrogen*

10B. KIND OF BUSINESS OR INDUSTRY

*self*

11. BIRTHPLACE (State or foreign country)

*Russia*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Albert Melnechuk*

14. MOTHER'S MAIDEN NAME

*Anna Petocki PETOCKI*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Daniel March 3609 Markide Drive*

18. *420.1*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

*Coronary Occlusion*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*William J. Helbuch*

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

*10-12-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*Oct 23 1950*

24C. NAME OF CEMETERY OR CREMATORY

*Holy Trinity Cem.*

24D. LOCATION (City, town, or county)

*Elkridge Md.*

DATE RECEIVED BY LOCAL REGISTRAR

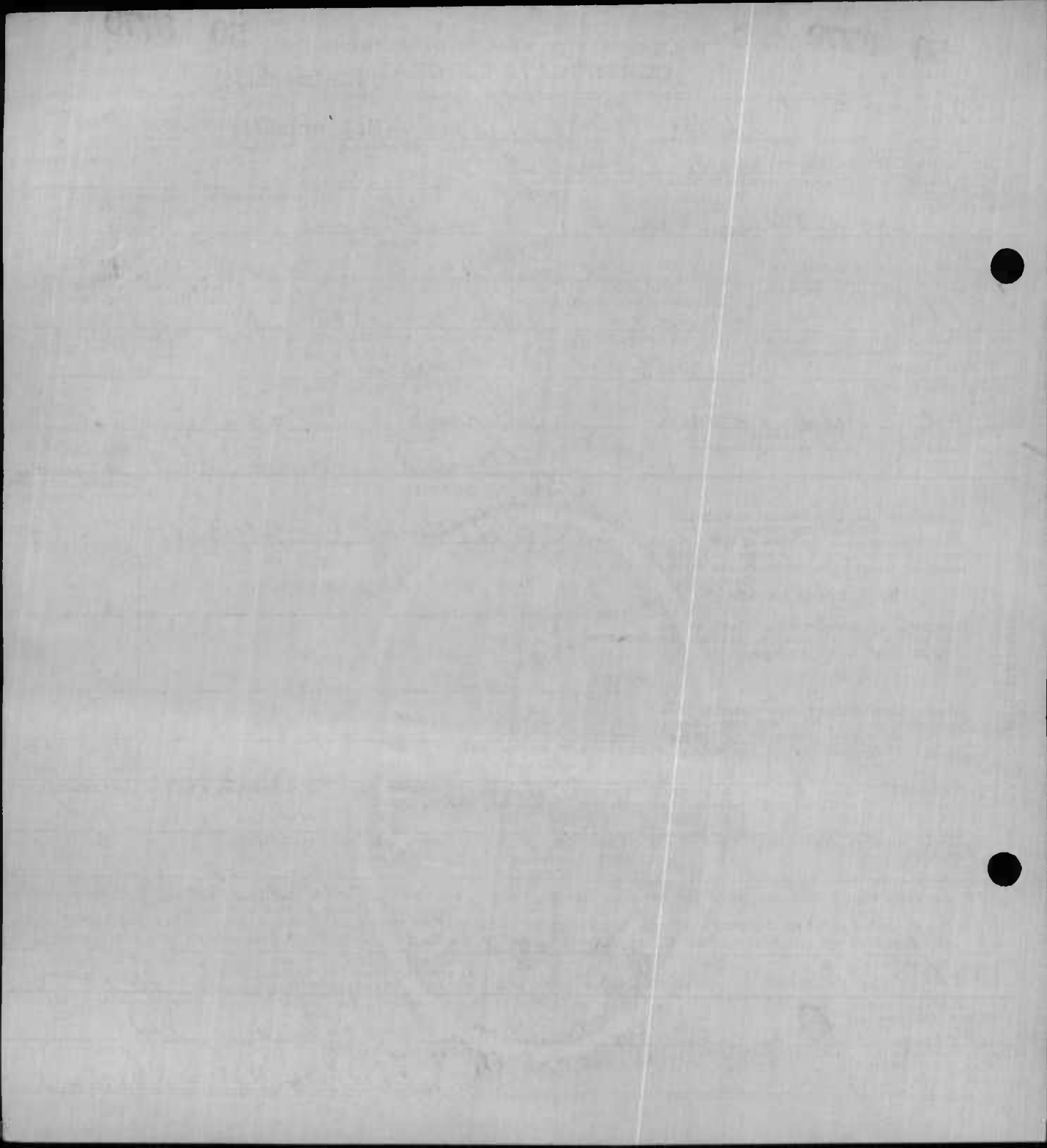
*OCT 13 1950*

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

*John W. W. 401 S. Chester*

ADDRESS



W-426

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>William J Wilkerson</i>			2. DATE OF DEATH <i>October 12, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1614 N Chester St</i>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Baltimore</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore Maryland</i>		
Length of stay in Baltimore <i>65 years</i>			D. STREET ADDRESS (If rural, give location) <i>8-06</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Jan 7 1866</i>	9. AGE (in years, last birthday) <i>84</i>	If Under 1 Year Months: Days: <i>9 3</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John Wilkerson Virginia</i>			14. MOTHER'S MAIDEN NAME <i>Susan Wilkerson Virginia</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Mr Doris L. Dietrich 1614 N Chester St</i>		

18. *442X*

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

*Cardiac Dilatation**2 days*

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

*Cardio Vascular Renal Disease**3 yrs -*

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *0* 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from *January 26, 1949* to *October 12, 1950*, that I last saw the deceased alive on *October 11, 1950*, and that death occurred at *6:00 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

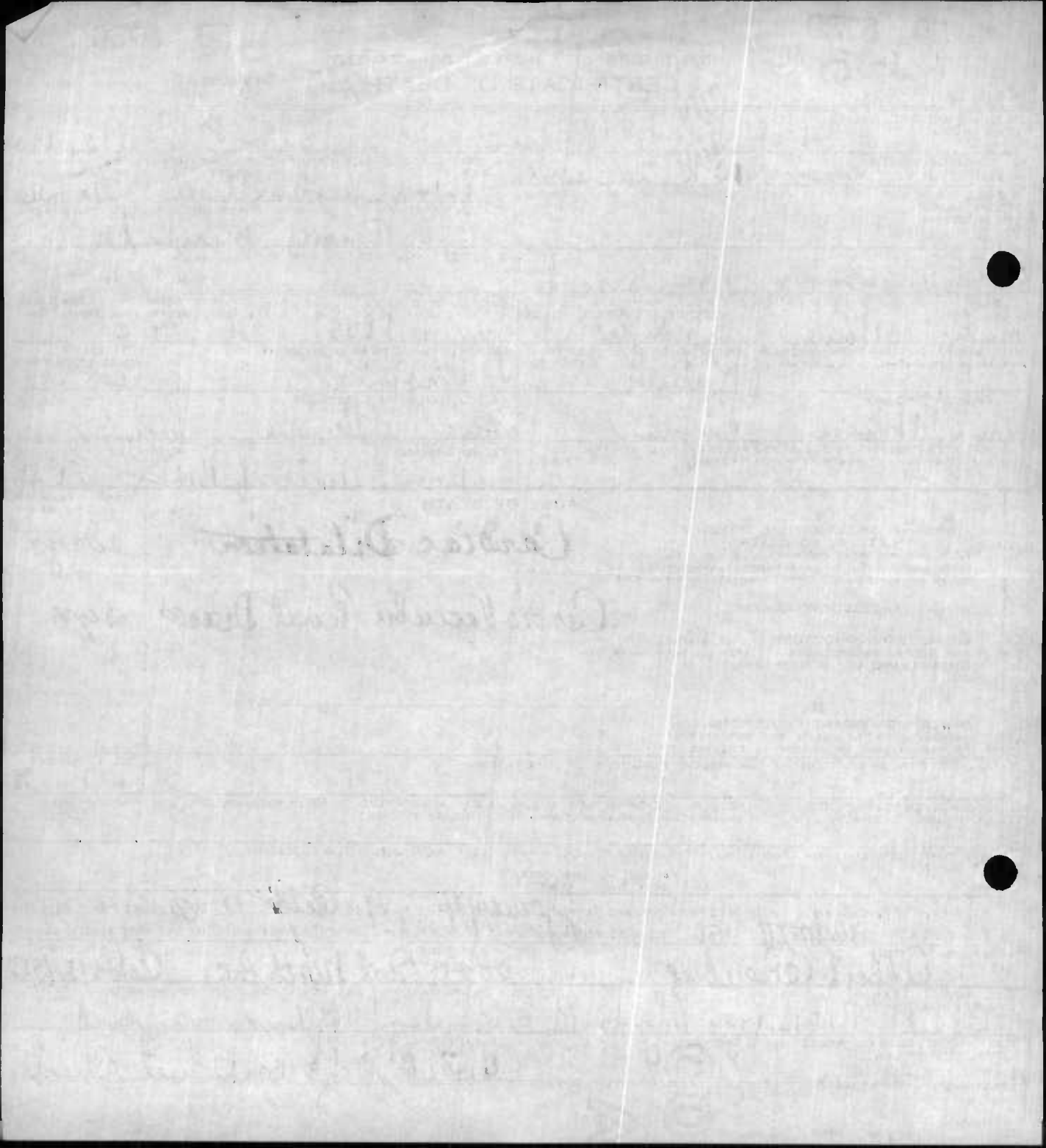
25. FUNERAL DIRECTOR

ADDRESS

OCT 13 1950

VS 150

131a





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**Helen Grace Hunter**

2. DATE OF DEATH **Oct. 13/50**

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
INSTITUTION **Lutheran Hospital**

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE **Md.** B. COUNTY \_\_\_\_\_

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore** **16-08**

D. STREET ADDRESS (If rural, give location)  
**3649 Gelston Drive**

Length of stay in Baltimore **Life**

5. SEX **Female** 6. COLOR OR RACE **White** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Married**

8. DATE OF BIRTH **Jan. 12, 1896** 9. AGE (in years last birthday) **54** 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**H.W. Co.**

10B. KIND OF BUSINESS OR INDUSTRY  
**Own Home**

11. BIRTHPLACE (State or foreign country)  
**Baltimore, Md.**

12. CITIZEN OF WHAT COUNTRY? \_\_\_\_\_

13. FATHER'S NAME  
**Frank Paterson**

14. MOTHER'S MAIDEN NAME  
**Catherine Wilson**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. \_\_\_\_\_

17. INFORMANT (husband) ADDRESS  
**Herbert T. Hunter, 3649 Gelston Drive**

18. **4 yr**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

(A) **Acute cardiac dilatation**

**3 hrs.**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Coronary sclerosis of liver**  
DUE TO **Chronic myocarditis**

**5 years**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **0** 19B. MAJOR FINDINGS OF OPERATION \_\_\_\_\_

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY **-**

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? **-**

22. I hereby certify that I attended the deceased from **10/17**, 19**50**, to **10/13**, 19**50**, that I last saw the deceased alive on **10/12**, 19**50**, and that death occurred at **5:30 a.m.**, from the causes and on the date stated above.

23A. SIGNATURE **Al Elias**

23B. ADDRESS **4 N. Fulton**

23C. DATE SIGNED **10/13/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)  
**Burial**

24B. DATE **Oct. 16/50**

24C. NAME OF CEMETERY OR CREMATORY **Woodlawn**

24D. LOCATION (City, town, or county) (State)  
**Woodlawn, Balto. Md.**

DATE RECEIVED BY LOCAL REGISTRAR  
**CT 13 1950**

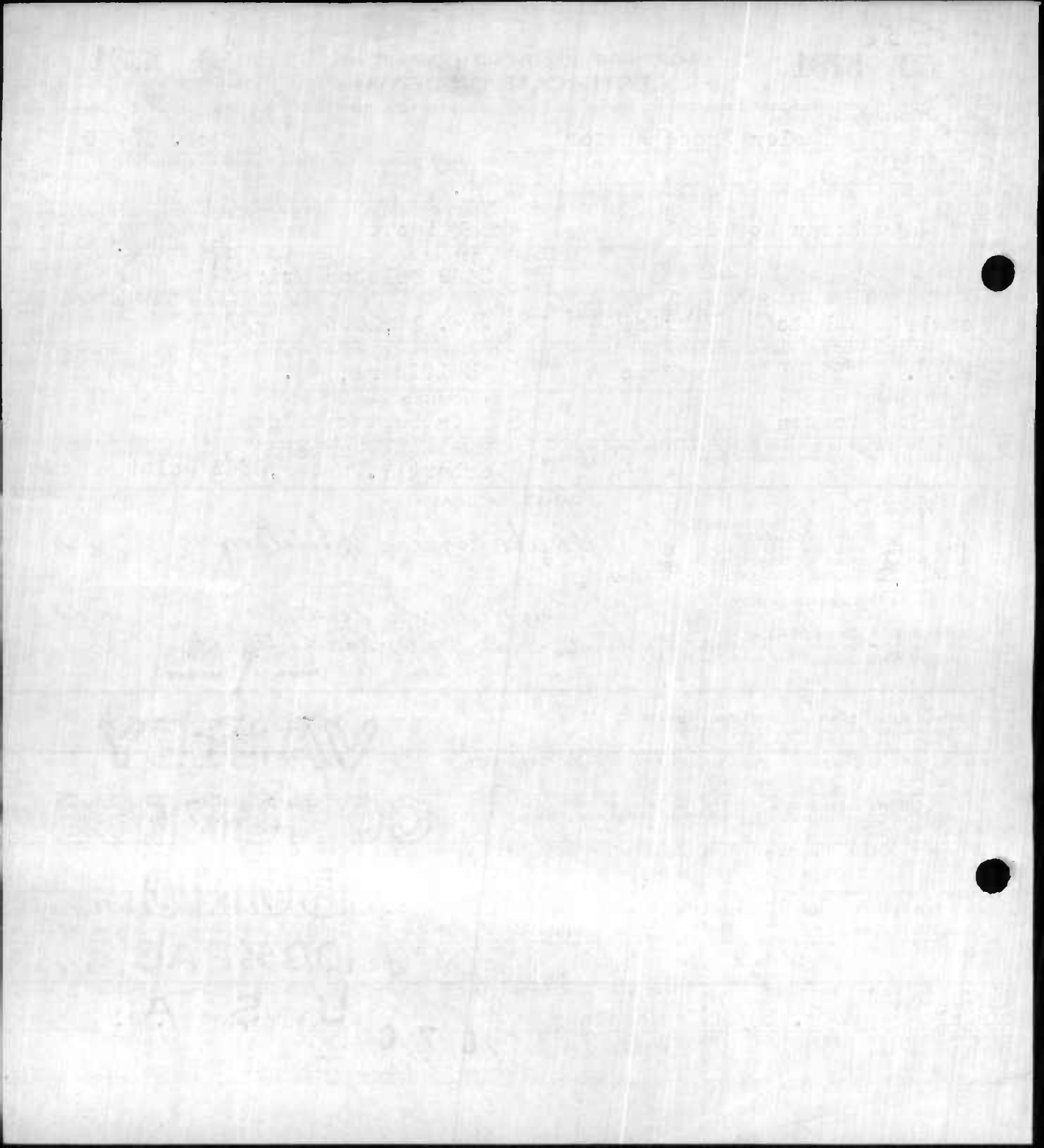
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**4101 Edmondson Ave.**

MEDICAL CERTIFICATION



E-220

50 8782

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8782  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Horace B. Essex

2. DATE  
OF  
DEATH

Oct. 11/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1801 Warwick Ave.

D. STREET ADDRESS (If rural, give location)

1801 Warwick Ave.

Length of stay in Baltimore

44 yrs.

5. SEX

Male

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 19, 1879

9. AGE (In years  
last birthday)

71

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Carpenter, Cabinet Maker, U. of Md.

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Wm. B. Essex

14. MOTHER'S MAIDEN NAME

Fannie Bowen

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL

217-05 9502

17. INFORMANT

ADDRESS

Mrs. Gertrude F. Essex, 1801 Warwick Ave.

18. 420.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

Coronary Thrombosis

Coronary Arteriosclerosis

Sensibility

INTERVAL BETWEEN  
ONSET AND DEATHSeveral  
Years

CERTIFICATION APPROVED BY

DR. John R. Davis

per: Stanley K. Duvall, M.D.

CHIEF OF ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

NOT WHILE

WORK ☐AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 11<sup>th</sup>, 1950, to Oct 11<sup>th</sup>, 1950, that I last saw the  
deceased alive on Oct 11, 1950, and that death occurred at 1:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Oct. 14/50

Woodlawn Cemetery, Woodlawn, Balto. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

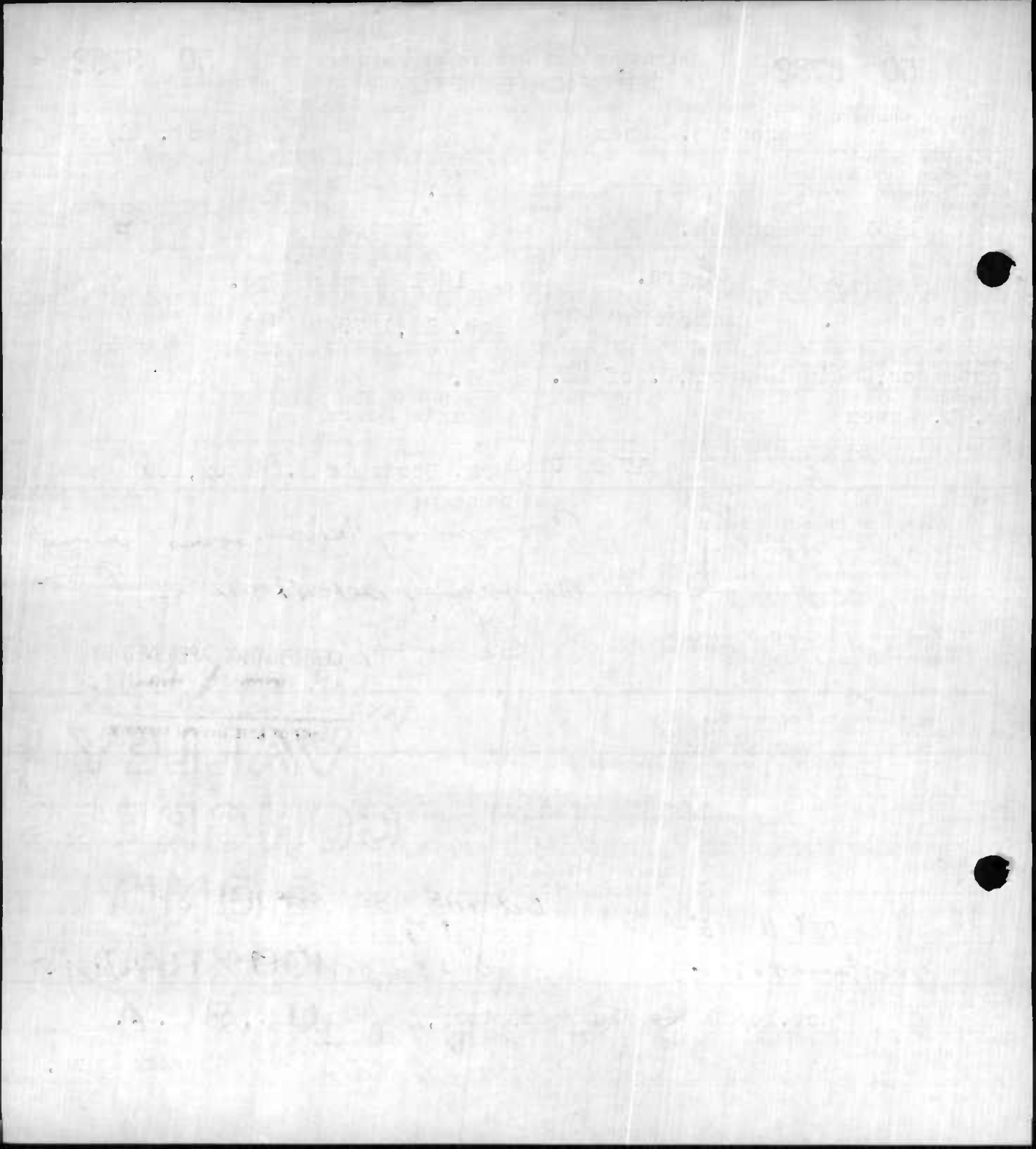
25. FUNERAL DIRECTOR

ADDRESS

OCT 13 1950

Harry H. Williams, M.D.

4101 Edmondson Ave.



S-436

8783

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8783  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

019a A. Slater

2. DATE  
OF  
DEATH

Oct. 12, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

1308 W. Lexington St.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

19-02

D. STREET ADDRESS (If rural, give location)

1308 W. Lexington St.

Yrs.  
Mos.  
Days

Length of stay in Baltimore

SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

3-10-1900

9. AGE (In years  
last birthday)

50

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

SEAMSTRESS

CLOTHING (M)

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

FRED W. SCHMIDT

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

220-095089

17. INFORMANT

ADDRESS

IRVING J. SLATER 1308 W. Lexington St.

18. 231X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cerebral Vascular Accident

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Kammer, Jr.

M.D.

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....23C. DATE SIGNED  
Oct. 12, 195024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

10-14-50

Wm. H. Kammer, Jr. Co.

Taylors Hill - Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

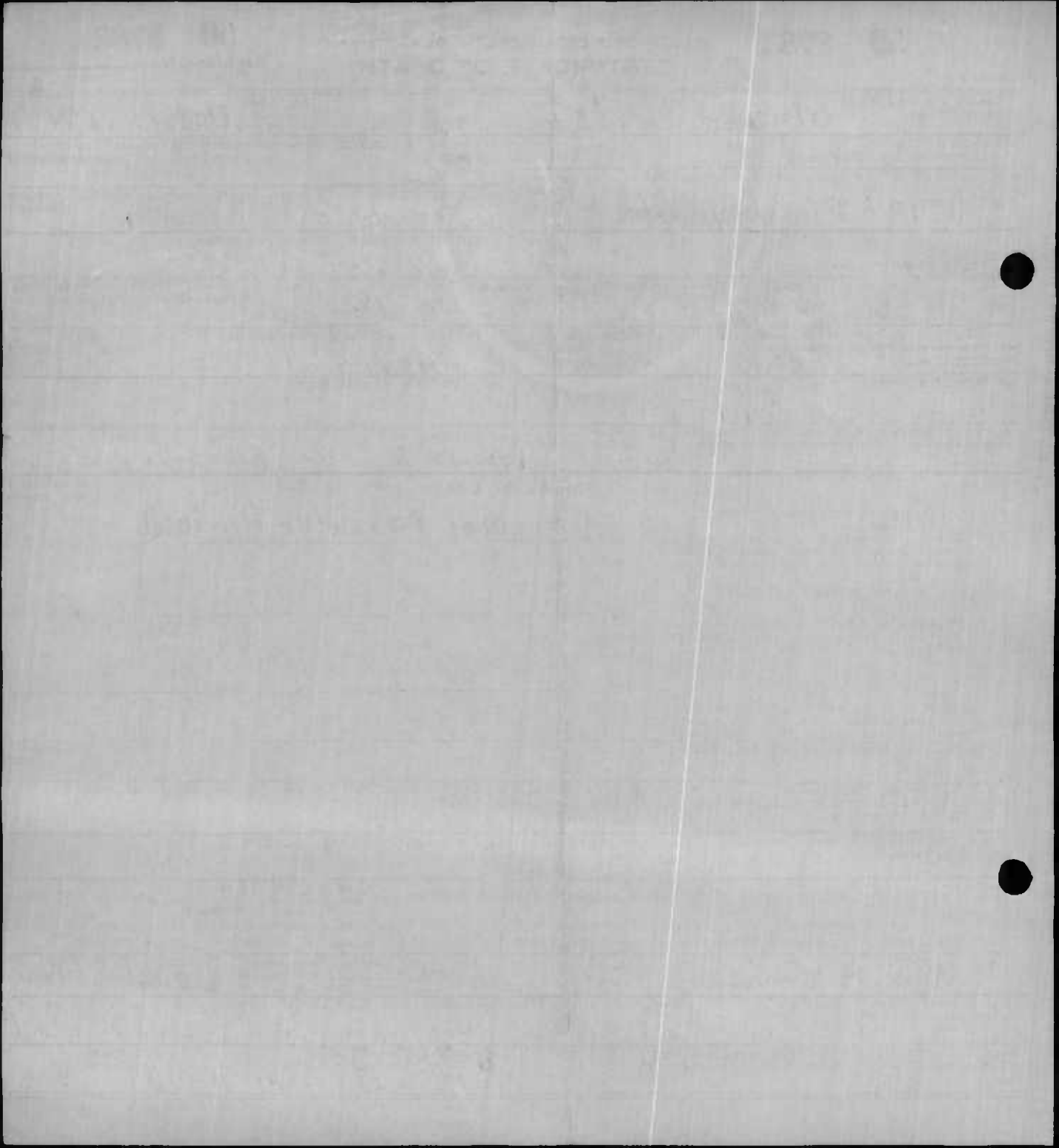
ADDRESS

OCT 13 1950

Wm. H. Kammer, Jr.

8783

1600 Hollins





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>William Walter TITTLE Sr.</b>		2. DATE OF DEATH <b>Oct. 11, 1950</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home &amp; Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>7-02</b>	
6. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		d. STREET ADDRESS (If rural, give location) <b>911 N. Luzerne Ave.</b>	
7. SEX <b>Male</b>	8. COLOR OR RACE <b>White</b>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	10. DATE OF BIRTH <b>January 8, 1895</b>
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oil Tester</b>		12. AGE (In years last birthday) <b>55</b>	
13. FATHER'S NAME <b>Wm. W. Tittle</b>		14. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, on or unknown) <b>no</b>		16. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
17. SOCIAL SECURITY NO. <b>215-07-2300</b>		18. MOTHER'S MAIDEN NAME <b>unknown</b>	
19. INFORMANT <b>Mrs. Frances Tittle, wife, above</b>		20. ADDRESS _____	

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Generalized arteriosclerosis</b> DUE TO	INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Coronary sclerosis with occlusion</b> DUE TO	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>William V. [Signature]</i>	23B. CHIEF MEDICAL EXAMINER M.D. <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	23C. DATE SIGNED <b>Oct. 11, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-14-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>
24D. LOCATION (City, town, or county) (State) <b>Fitchie Highway, Balto. Md.</b>	25. FUNERAL DIRECTOR <b>Chilman's Federal Home, Inc.</b> <b>2601-3-5 E. Madison St.</b>	
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>[Signature]</i>	

VSG:1 31550

09522

94a ✓

Correct age is especially important. Physicians, please write the causes of death clearly and legibly.

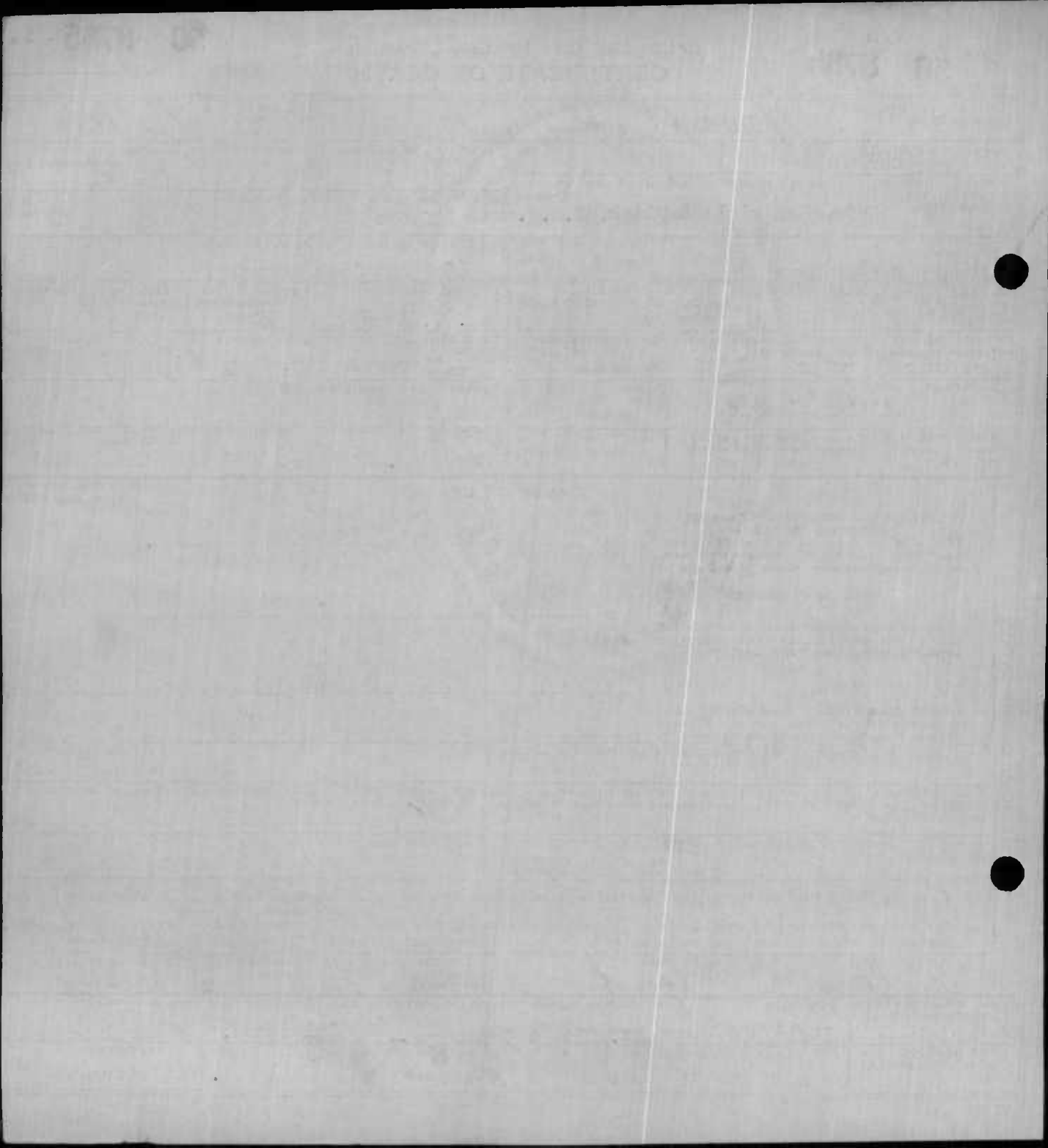
MEDICAL CERTIFICATION



correct age is especially important. Physicians: please write the causes of death clearly and legibly.

F-424 50 8785				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				50 8785 Registered No.			
BIRTH NO.				1. NAME OF DECEASED (Type or Print)				2. DATE OF DEATH			
				Howard L. Fleagle				Oct 12, 1950			
3. PLACE OF DEATH:				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
A. Baltimore City, Maryland				A. STATE Maryland				B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)							
Union Memorial Hospital, D.O.A.				Baltimore				9-03			
Length of stay in Baltimore				D. STREET ADDRESS (If rural, give location)							
Yrs. Mos. Days				609 East 35th Street							
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Year Months: Days	
M		W		married		Jan. 9, 1895		55			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Streetcar Operator				Baltimore Transit Co.				Baltimore County, Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
William Fleagle											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
no								Howard J. Fleagle, 1863 Loch Shiel Road			
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH Coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH			
(A) DUE TO											
ANTECEDENT CAUSES				(B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK				21F. HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .											
23A. SIGNATURE William G. Helfrich				23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....				23C. DATE SIGNED 10-12-50			
24A. BURIAL, CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY OR CREMATORY			
burial				10/16/50				Mt. Olivet Cemetery			
DATE RECEIVED BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE				24D. LOCATION (City, town, or county) (State)			
OCT 13 1950				William G. Helfrich				Baltimore, Maryland			
				25. FUNERAL DIRECTOR				ADDRESS			
				H.M. Cook, Inc.,				1217 St. Paul Street			
VS 151				661 51				094a			

MEDICAL CERTIFICATION



G-600  
50 8786BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8786

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MRS. ALICE R. GRAY</b>			2. DATE OF DEATH <b>OCT. 12, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 14 Parkville</b>		
Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>2911 MANN'S AVE. 5200</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>W</b>	8. DATE OF BIRTH <b>SEPT. 9, 1878</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			11. BIRTHPLACE (State or foreign country) <b>FREDERICK, MD.</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>GEORGE KEEFER</b>			14. MOTHER'S MAIDEN NAME <b>MARY HEMBURY</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>PATIENT</b>			ADDRESS		

18. <b>631X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>PULMONARY EMBOLI, BILATERAL</b> DUE TO (B) <b>PELVIC PHLEBOTHROMBOSIS</b> DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <b>9-16-50</b>	19B. MAJOR FINDINGS OF OPERATION <b>Prolapsed Uterus</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **SEPT. 8**, 19**50**, to **OCT. 12**, 19**50**, that I last saw the deceased alive on **OCT. 12**, 19**50**, and that death occurred at **6:15 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>Richard Beach</b>	23B. ADDRESS M. D. <b>Union Memorial Hospital</b>	23C. DATE SIGNED <b>10-12-50</b>
--	--	-------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-16-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 13 1950</b>	REGISTRAR'S SIGNATURE <b>W. E. O. O.</b>	25. FUNERAL DIRECTOR <b>Leonard J. Luck</b>	ADDRESS <b>5305 Harford Rd</b>

VS 150

100-6

1935

1935

1935



P-116

50 8787

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8787

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN C. PFEIFER

2. DATE  
OF  
DEATH

10/12/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE MD B. COUNTY before admission)B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

NO 1020 RUSSELL ST

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

BALTIMORE

21-01

D. STREET ADDRESS (If rural, give location)

1020 RUSSELL ST

Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

10/9/1875

9. AGE (in years  
last birthday)

75

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

STOCK CLERK

10B. KIND OF BUSINESS OR  
INDUSTRY

MANUFACTURING

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MRS EDNA MAY PFEIFER 1020 RUSSELL ST

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebral hemorrhage

6 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) General arterio sclerosis

?

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 10/7/50, 19\_\_\_\_, to 10/12/50 19\_\_\_\_, that I last saw the  
deceased alive on 10/12/50 and that death occurred at 10.15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

1226 Hanover Street,

10/13/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

10/14/50

LODGE PARK

FREDERICK RD.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 14 1950

1250 000000

840 P. O. BOX 715 LIGHT ST -30

VS 150

083a

MEDICAL CERTIFICATION

Correct age is especially important in infant deaths

Dr. Kleiber

8 to 11 am

7 to 8 pm

LC 142198

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)Chapman  
William Delcher2. DATE  
OF  
DEATH

Oct. 12, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION Baltimore City Hospitals  
4940 Eastern Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE Maryland

B. COUNTY before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

1725 Ashburton Street

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

June 30, 1873

9. AGE (in years

last birthday)  
77

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Floorman10B. KIND OF BUSINESS OR INDUSTRY  
Savings Bank

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Delcher

14. MOTHER'S MAIDEN NAME

Mary Baron

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Records- Baltimore City Hospitals  
4940 Eastern Avenue

1B. 420.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure

DUE TO

3 Mos.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Heart Disease

DUE TO

2 Mos.

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 3, 1950 to Oct. 12, 1950, that I last saw the deceased alive on Oct. 12, 1950, and that death occurred at 7:50 PM, from the causes and on the date stated above.

23A. SIGNATURE

J. S. Rogers M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

10-12-50

24A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

24B. DATE

10/16/50

24C. NAME OF CEMETERY OR CREMATORY

Balto/ Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

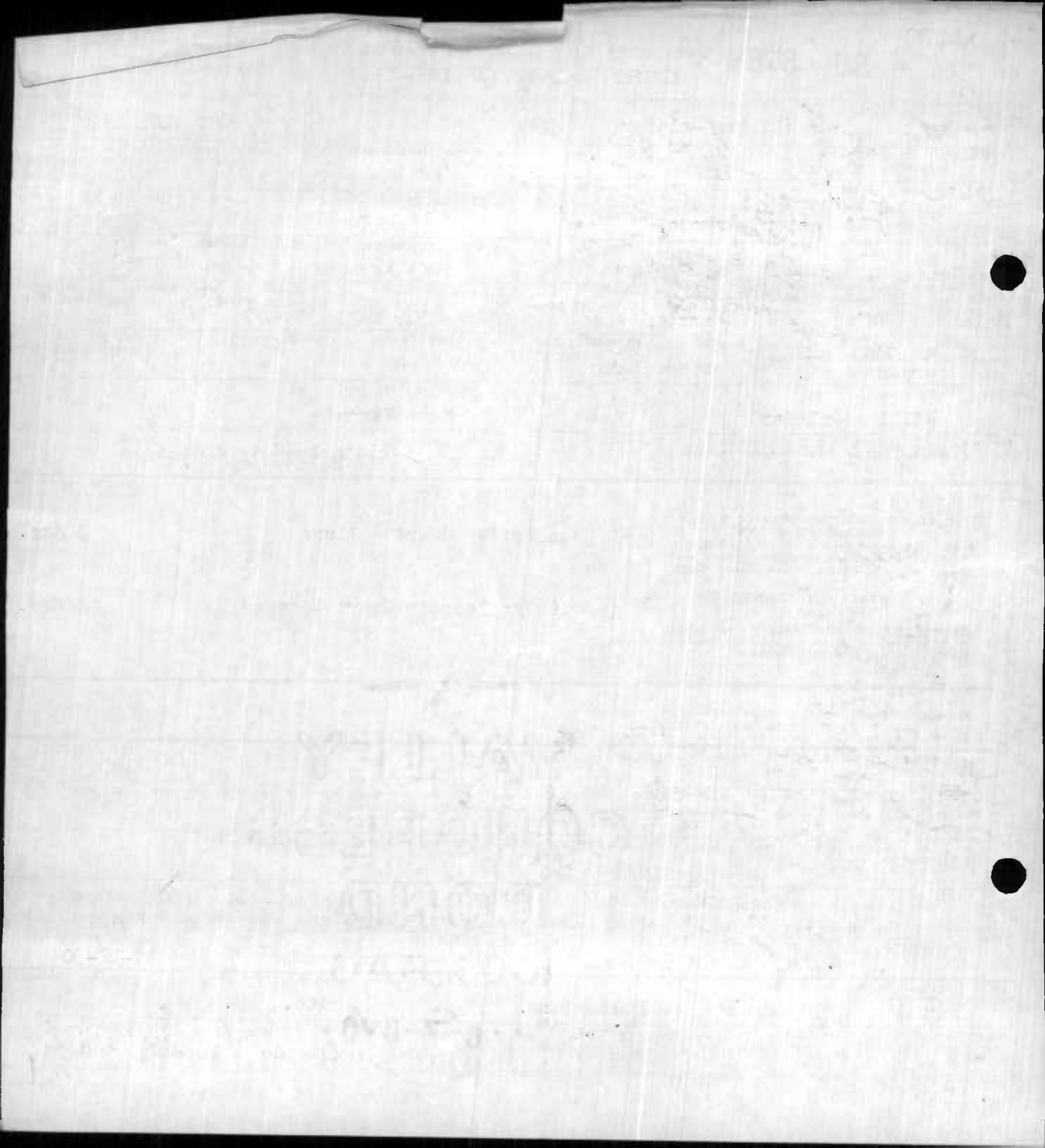
ADDRESS

Jm. J. Schenck &amp; Sons - Balto. Md.

VS 150

0932

correct age is especially important. Physicians please write the cause of death.



H-630

50 8789

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8789  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FLORENCE E. HART

2. DATE  
OF  
DEATH

10/12/50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION 5002 Embla Ave.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
Md.C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

5002 Embla Ave.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
widowed

8. DATE OF BIRTH

Aug. 26, 1872

9. AGE (In years  
last birthday)

78

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
housewife10B. KIND OF BUSINESS OR  
INDUSTRY  
at home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Emanuel Beck

14. MOTHER'S MAIDEN NAME

Georganna -

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. J. H. Hoffman - 5002 Embla Ave.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Physical collapse &amp; heat prostration Sept 5th-50

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 5, 1950, to Oct 12, 1950, that I last saw the  
deceased alive on Oct 12, 1950, and that death occurred at 1:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

John W. V. Clift

M. D.

23B. ADDRESS

5010 Greenleaf Road

23C. DATE SIGNED

Oct 13-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
Burial

24B. DATE

10/16/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24D. LOCATION (City, town, or county)

Pikesville, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 14 1950

Wm. J. Richner &amp; Sons - Balt. Md.

1947

CERTIFICATE OF DEATH

1947

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1947



K-420

50 8790

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>John Frank Klick</i>		2. DATE OF DEATH <i>Oct. 14, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto. Md.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>4908 E. Federal St.</i> B. COUNTY <i>Balto. Md.</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>4908 E. Federal St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto. Md. 26-03</i>	
5. Length of stay in Baltimore <i>2 years</i>		D. STREET ADDRESS (If rural, give location) <i>4908 E. Federal St.</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>June 14, 1888</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Miner</i>	10B. KIND OF BUSINESS OR INDUSTRY <i>Laborer</i>	9. AGE (In years last birthday) <i>62</i>	11. BIRTHPLACE (State or foreign country) <i>Shenandoah, Penna.</i>
13. FATHER'S NAME <i>John Klick</i>		14. MOTHER'S MAIDEN NAME <i>Anna Yanoska</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. J. A. Gostong</i>		ADDRESS <i>49026 E. Federal St.</i>	

18. *443X*

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Myocarditis*  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Hypertensive Cardiovascular disease*  
DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) *(1) atelectasis (2) asthma*19A. DATE OF OPERATION *0*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *11-5*, 19*50*, to *10-13*, 19*50*, that I last saw the deceased alive on *10-13*, 19*50*, and that death occurred at *5:45* p. m., from the causes and on the date stated above.

23A. SIGNATURE *L. J. Bell*23B. ADDRESS *2601 E. McNamee St.*23C. DATE SIGNED *10/14/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE *Oct 14, 1950*24C. NAME OF CEMETERY OR CREMATORY *Shenandoah P.A.*

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE *Joseph Farace Jr*

25. FUNERAL DIRECTOR

ADDRESS *2013 Greenmount Ave*

VS 150

65021

093d

MEDICAL CERTIFICATION

See Document File for amendment authorization.

10-31-50

Ed

R-262

50 8791

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Jesse Howard Rogers</b>		2. DATE OF DEATH <b>10-10-50</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
5. Length of stay in Baltimore <b>Life</b> Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>222 N. Mount Street (23)</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>July 13, 1937</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>13</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Colbert</b>		14. MOTHER'S MAIDEN NAME <b>Florence Rogers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Records* Balto. City Hospitals Eastern Ave</b>		ADDRESS <b>4940</b>	

18. <b>193X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, athenia, etc. It means the disease, injury or complication which caused death.) <b>Neuroblastoma, primary sight unknown to &amp; wide spread Metastasis.</b>	INTERVAL BETWEEN ONSET AND DEATH <b>4- mos.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ DUE TO (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>8-24-50</b>		19B. MAJOR FINDINGS OF OPERATION <b>Biosis</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. _____ WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **8-24**, 19**50**, to **10-10**, 19**50**, that I last saw the deceased alive on **10-10**, 19**50**, and that death occurred at **3:10pm** from the causes and on the date stated above.

23A. SIGNATURE <b>J. Rogers</b> M. D.	23B. ADDRESS <b>4940 Eastern Avenue</b>	23C. DATE SIGNED <b>10-11-50</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-14-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Western Star</b>	24D. LOCATION (City, town, or county) (State) <b>Catonsville Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>Mr. R. Williams</b>	25. FUNERAL DIRECTOR <b>Mr. R. Williams</b>	

TEST COPY OF DEATH

1/28/71

M-343

50 8792

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8792

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES MIDDLETON JR.

2. DATE  
OF  
DEATH

10/8/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1119 Race St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 23-01

D. STREET ADDRESS (If rural, give location)

1119 Race St

Length of stay in Baltimore

48

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Cot.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

1876

9. AGE (In years last birthday)

74

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Junk Dealer

10B. KIND OF BUSINESS OR INDUSTRY

Plasterer

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Charles Middleton

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Clarence Middleton 413 W Barre

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocarditis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension nephrotic

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/10/50 to 10/8/50, that I last saw the deceased alive on 10/7/50, and that death occurred at 12:40 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FURNERAL DIRECTOR

ADDRESS

OCT 14 1950

J. L. Brown &amp; Son - Montgomery St

VS 150

573 24

937

Correct age is especially important. Physicians: please note the cause of death clearly and legibly.

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

STATE OF NEW YORK

NO. 1000

DECEASED

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Burial Officer

Signature of Minister of Religion

Signature of Undertaker

Signature of Funeral Home

Signature of Cemetery

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment



R-200

50

8793

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Nannie Rice

2. DATE  
OF  
DEATH

10/12/50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3814 Norfolk Ave

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

3814 Norfolk Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balt. Md 15-17

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

3814 Norfolk Ave

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

Female White

Married

Aug 19/1894

76

1 23

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTH PLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

Housewife

Brooklyn N.Y.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Harry Stokvis

Leon Marks

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT  
Mr. Milton Tegenbrum

18. 260X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Myocardial infarction

3 years

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Diabetes mellitus

15 years

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from May, 1935, to Oct 12, 1950, that I last saw the  
deceased alive on Oct 12, 1950, and that death occurred at 9:11 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Nannie Rice

M. D.

1720 E. 11th Ave.

Oct 14/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Oct 15/50

Baltimore Hebrew Cem.

Belair Park

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

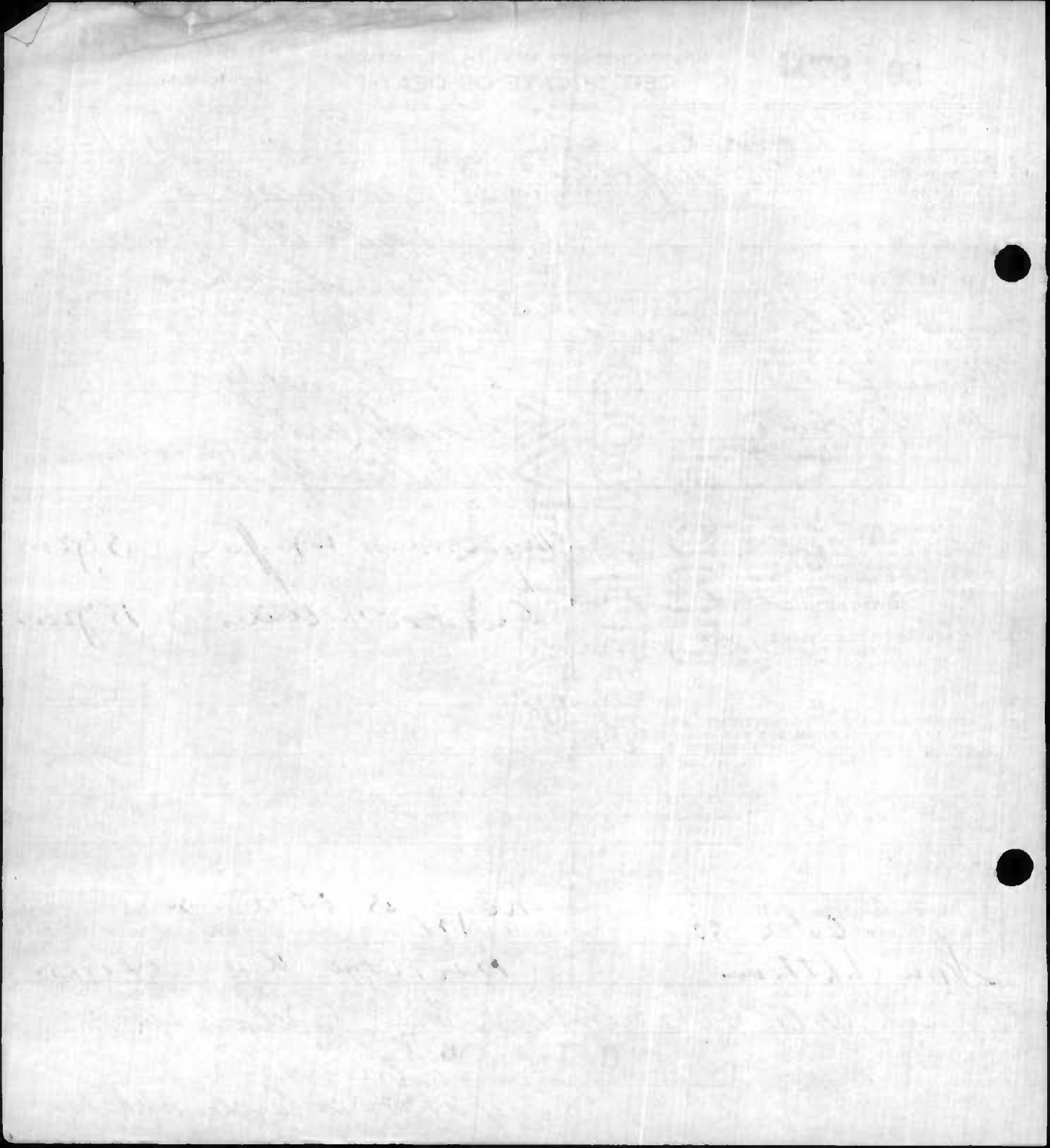
ADDRESS

11-14-1950

11-14-1950

J. Ahrens Co.

2432 Reisterstown Rd-17  
061.0



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 8794

BIRTH NO. 50 8794

1. NAME OF DECEASED (Type or Print) <b>H ARRIETT B. GRAY</b>			2. DATE OF DEATH <b>Oct 13, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Towson</b>		
Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>610 York Road 5300</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>Oct. 21, 1864</b>		9. AGE (In years last birthday) <b>85</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Cambridge, Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Unknown Dudrow</b>		
14. MOTHER'S MAIDEN NAME <b>Unknown</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		
16. SOCIAL SECURITY NO. <b>No</b>			17. INFORMANT ADDRESS <b>Mabel C. Gray, Towson, Maryland</b>		

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Vascular Accident</b> DUE TO <b>Probably Hemorrhage into Rt. Internal Capsule.</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <b>causing Left Hemiparesis &amp; aphasia</b> DUE TO <b>Hemiparesis &amp; aphasia</b>		
(C) <b>Arterio-Sclerotic - Hypertensive</b> <b>Cerebro-Vascular Disease</b>		
II OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

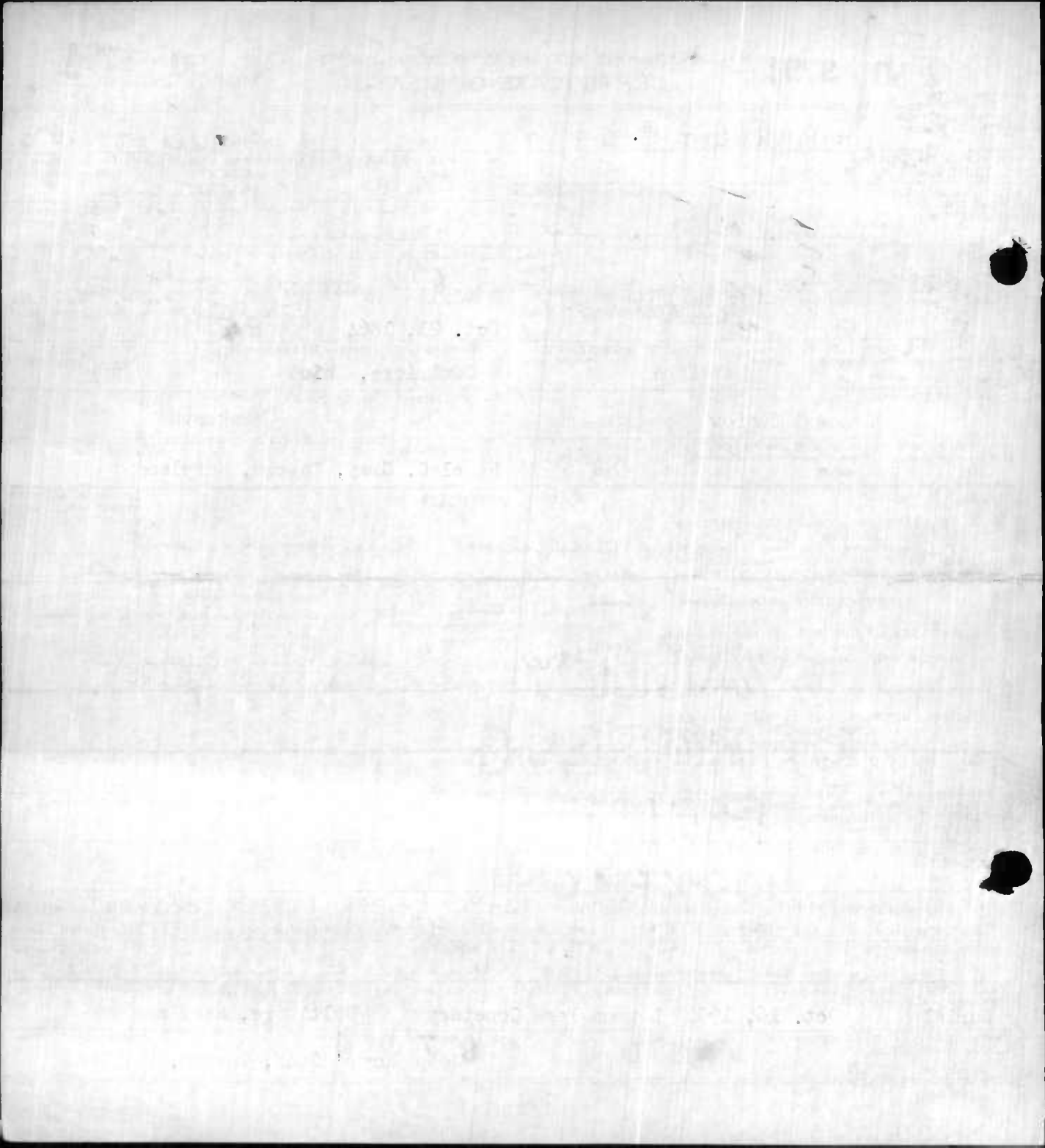
19A. DATE OF OPERATION <b>None</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 10-9 1950 to 10-13, 1950 that I last saw the deceased alive on 10-12, 1950 and that death occurred at 4:20 A.M., from the causes and on the date stated above.

23A. SIGNATURE <b>Elmer W. Demarest</b> M.D.		23B. ADDRESS <b>University Hosp.</b>		23C. DATE SIGNED <b>10-13-50</b>	
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Oct. 16, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
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DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 14 1950</b>	REGISTRAR'S SIGNATURE <b>John Burns</b>	25. FUNERAL DIRECTOR <b>John Burns Sons, Towson, Maryland</b>	ADDRESS
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5-300

50 8795

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 8795

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Louise R. Scott

2. DATE  
OF  
DEATH

Oct. 10, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

520 Dolphin St.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 17-02

D. STREET ADDRESS (If rural, give location)

520 Dolphin St.

Length of stay in Baltimore

59 yrs.

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Sept. 2, 1872

9. AGE (In years

last birthday)

78

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Daniel Brown

14. MOTHER'S MAIDEN NAME

Louise ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No.

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Ethel Scott Bowling

ADDRESS

520 Dolphin St.

18. 321X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral Hemorrhage

2 days

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-8, 1950, to 10-10, 1950, that I last saw the deceased alive on 10-10, 1950, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Stanford P. Immers

M. D.

23B. ADDRESS

2309 Druid Hill Ave.

23C. DATE SIGNED

10-14-50.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 14, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

OCT 14 1950

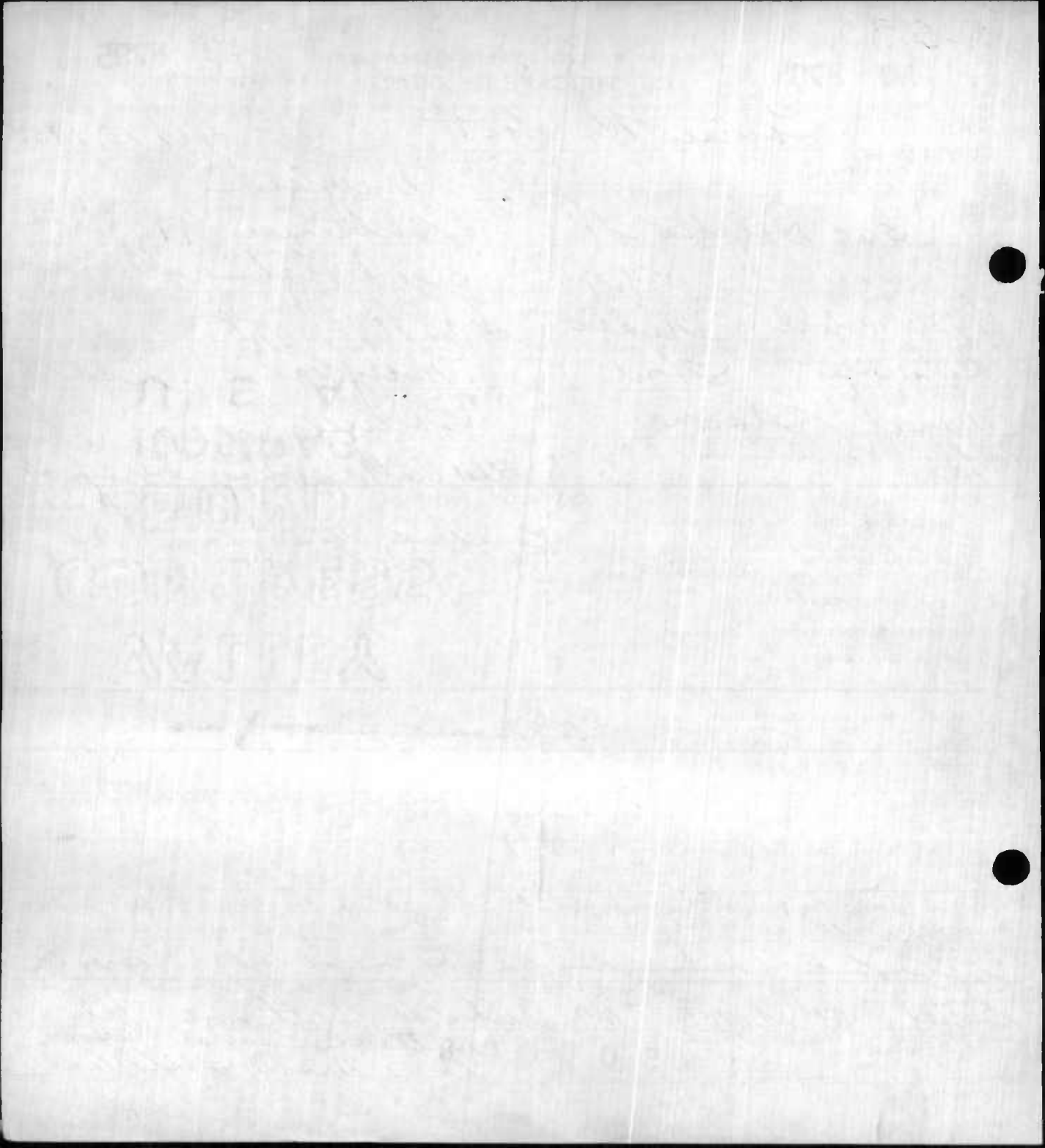
25. FUNERAL DIRECTOR

Funeral Home 1631 Druid Hill Ave.

VS 150

083a

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>MISS ELLEN BROSNAN.</b>		2. DATE OF DEATH <b>OCTOBER 13 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>BALTIMORE CITY</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>4301 ROLAND AVE</b> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>KIRKLEIGH VILLA.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE CITY. 27-14</b>	
D. STREET ADDRESS (If rural, give location) <b>4301 ROLAND AVE.</b>		E. LENGTH OF STAY IN BALTIMORE <b>8 years</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Dec. 23, 1860</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>Timothy Brosnan</b>		12. CITIZEN OF WHAT COUNTRY? <b>Ireland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Miss Ellen Brosnan</b>		ADDRESS <b>4301 Roland Ave.</b>	

<p>18. <b>422.1</b></p> <p><b>I</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	<p>(A) <b>CHRONIC MYOCARDITIS DECEMBER 28 1949.</b></p> <p>DUE TO</p>		
	<p>(B) <b>ARTERIOR SCLEROSIS.</b></p> <p>DUE TO</p>		
	<p>(C) <b>CHRONIC ARTHRITIS.</b></p>		

19A. DATE OF OPERATION <b>NONE</b>		19B. MAJOR FINDINGS OF OPERATION <b>NONE</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
<p>22. I hereby certify that I attended the deceased from <b>DECEMBER 28, 1949</b>, to <b>OCT 13, 1950</b>, that I last saw the deceased alive on <b>OCT 13, 1950</b>, and that death occurred at <b>5.15 PM</b>, from the causes and on the date stated above.</p>				
23A. SIGNATURE <i>Chas. P. Clautice</i>		23B. ADDRESS <b>3013 ST PAUL STREET.</b>		23C. DATE SIGNED <b>OCT 13 1950</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Monte Marie, Towson, Md.</b>	24D. LOCATION (City, town, or county) (State) <b>Towson, Maryland</b>
25. FUNERAL DIRECTOR <b>H. W. Meadison</b>		ADDRESS <b>805 N. Calvert st.</b>	

VS 150

093 C

TO : DIRECTOR, FBI (100-100000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

100-100000

C-462

50 8797

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

JOHN M. CLARK

2. DATE  
OF  
DEATH

10/12/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 675 E. Clement St.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Md. B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 24-02D. STREET ADDRESS (If rural, give location)  
675 E. Clement Street

Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Fireman

10B. KIND OF BUSINESS OR INDUSTRY

Balto. City F.D.

13. FATHER'S NAME

Jasper Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

12/2/1890

9. AGE (in years last birthday)

59

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Mary Getz

17. INFORMANT

ADDRESS

Family - Same

18. 422.2

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocardial Degeneration

9 mo.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)  
DUE TO  
(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic Nephritis

6 mo.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-4 1950 to 10-12, 1950, that I last saw the deceased alive on 10-11, 1950, and that death occurred at 1 A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

B

24B. DATE

10/16/50

24C. NAME OF CEMETERY OR CREMATORY

Western

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

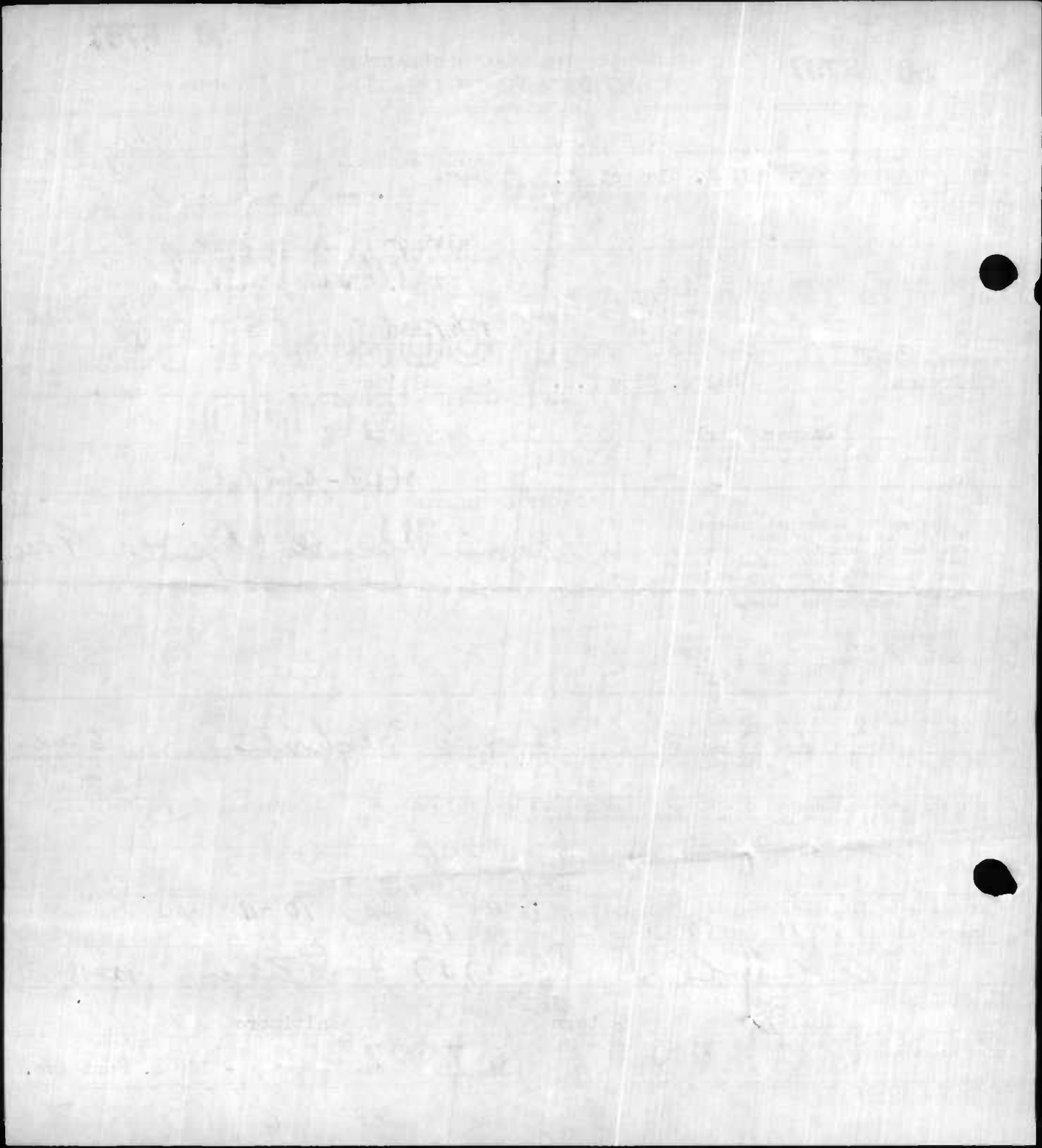
- 130 E. Fort Ave.

OCT 16 1950

76293

131a

MEDICAL CERTIFICATION



A-240

CERTIFICATE CORRECTED 10-19-50

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HELEN V. ACKLEY

2. DATE  
OF  
DEATH

October 13, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland Carroll

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

UNIVERSITY HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Westminster

D. STREET ADDRESS (If rural, give location)

Bond St.

5641

Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

F

W

Widowed

Nov. 19, 1886

63

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

Practical nurse

private home

11. BIRTHPLACE (State or foreign country)

Carroll Co. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George W. Armacost

14. MOTHER'S MAIDEN NAME

Virginia Herring

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Henry Ackley, Manager St. Anne's Pk.

18. 153 X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) GENERALIZED PERITONITIS

8 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) INTESTINAL OBSTRUCTION

8 days

(C) lower Nephron Nephrosis

5 days

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Post-operative Ca of Sigmoid

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

9/22/50

CARCINOMA OF SIGMOID

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐I hereby certify that I attended the deceased from Oct. 5, 1950, to Oct. 13, 1950, that I last saw the  
deceased alive on Oct. 13, 1950, and that death occurred at 11:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Charles T. Henderson

M. D.

University Hospital

Oct. 14, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. GENERAL DIRECTOR

ADDRESS

Burial

Oct 16, 1950

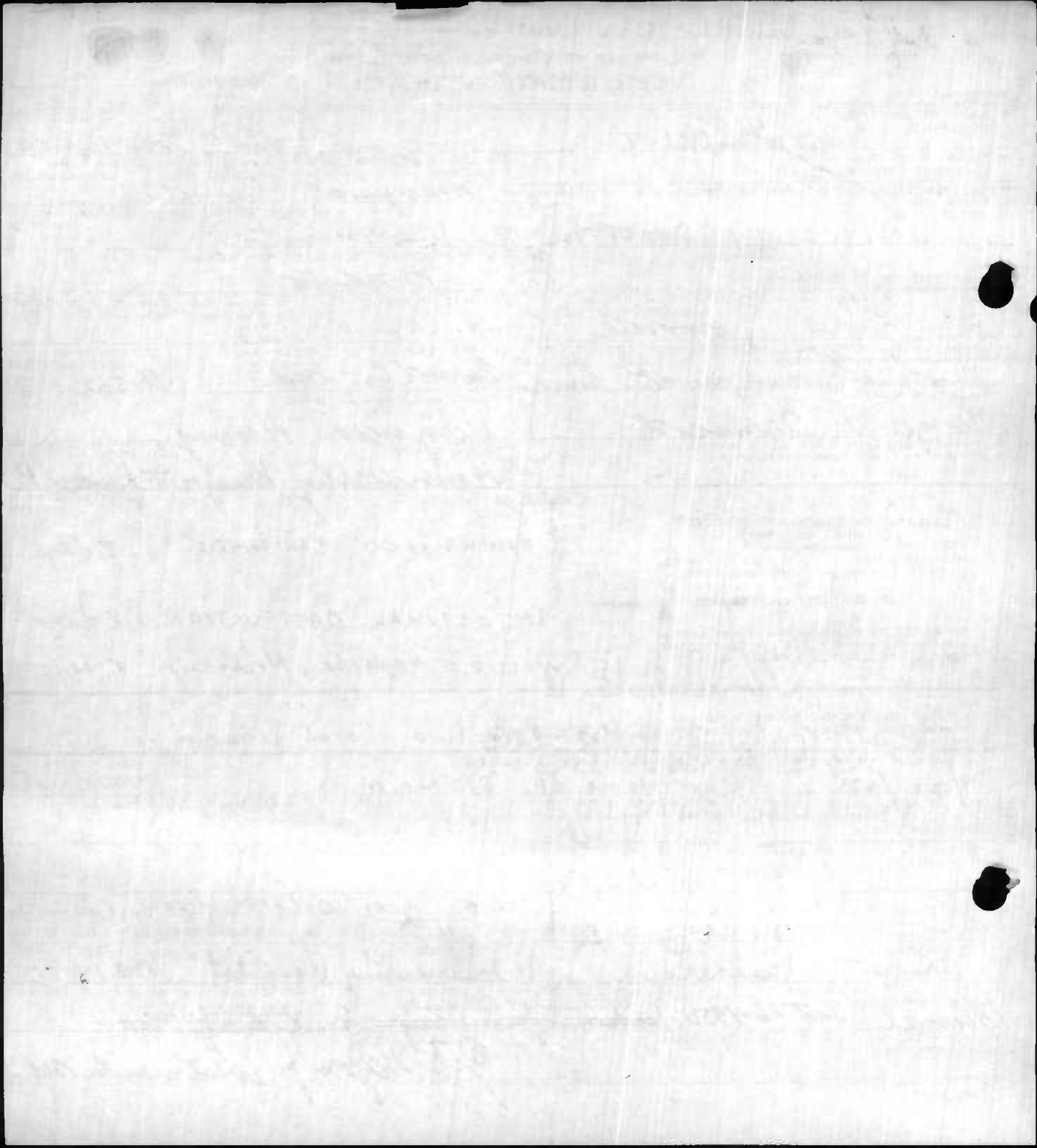
Westminster Cemetery

Westminster, Md.

OCT 15 1950

7818A

0462





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Robert Mullins*

2. DATE  
OF  
DEATH

*Oct 14, 50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

*JOHNS HOPKINS HOSPITAL*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

8. DATE OF BIRTH

*6-1-50*

9. AGE (In years last birthday)

If Under 1 Year Months Days Hours: Min.

11. BIRTHPLACE (State or foreign country)

*W. Va.*

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

*Beatrice ?*

13. FATHER'S NAME

*Morton Mullins*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

*JOHNS HOPKINS HOSPITAL*

ADDRESS

18. *754.6*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

*transposition of great vessels*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

*10/14/50*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

I hereby certify that I attended the deceased from *Oct 6 to 19 50* *Oct 14, 1950* that I last saw the deceased alive on *Oct 14, 1950* and that death occurred at *10-2* m., from the causes and on the date stated above.

23A. SIGNATURE

*Lee M. Bass*

M. D.

23B. ADDRESS

*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

*BURIAL*

24B. DATE

*Oct 14-50*

24C. NAME OF CEMETERY OR CREMATORY

*KEYSTONE*

24D. LOCATION (City, town, or county)

*W. VA.*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*William H. Williams*

25. FUNERAL DIRECTOR

*John & Mitchell*

ADDRESS

*1900 Eutan Pl.  
1574*

*[Faint, illegible handwriting and bleed-through from the reverse side of the page are visible throughout the document.]*

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Mary Sizer*

2. DATE  
OF  
DEATH

*Oct 13 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

*Maryland*

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

*University Hospital*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Baltimore*

*16-08*

D. STREET ADDRESS (If rural, give location)

*3907 Rokey Rd.*

Length of stay in Baltimore

Yrs.  
Mos.  
Days

SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years  
last birthday)

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

*Female*

*white*

*Aug. 14 1886*

*64*

*1 29*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

*Housewife*

*Virginia*

13. FATHER'S NAME

14. MOTHER'S/MAIDEN NAME

*William Garnett*

*Mary Fogg*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Mary G. Tuck 3907 Rokey Rd.*

18. *581.0*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

*Cirrhosis of liver*

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

*Oct-5, 1950*

*Cirrhosis of liver*

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

I hereby certify that I attended the deceased from *Oct 3*, 1950 to *Oct 13*, 1950, that I last saw the deceased alive on *Oct 13*, 1950, and that death occurred at *11:50* a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

*Raymond Bradshaw Jr.*

*University Hospital, Balto Md Oct. 14 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

*Removal*

*10-14-50*

*Belah Church Cemetery*

*King William County, Virginia*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

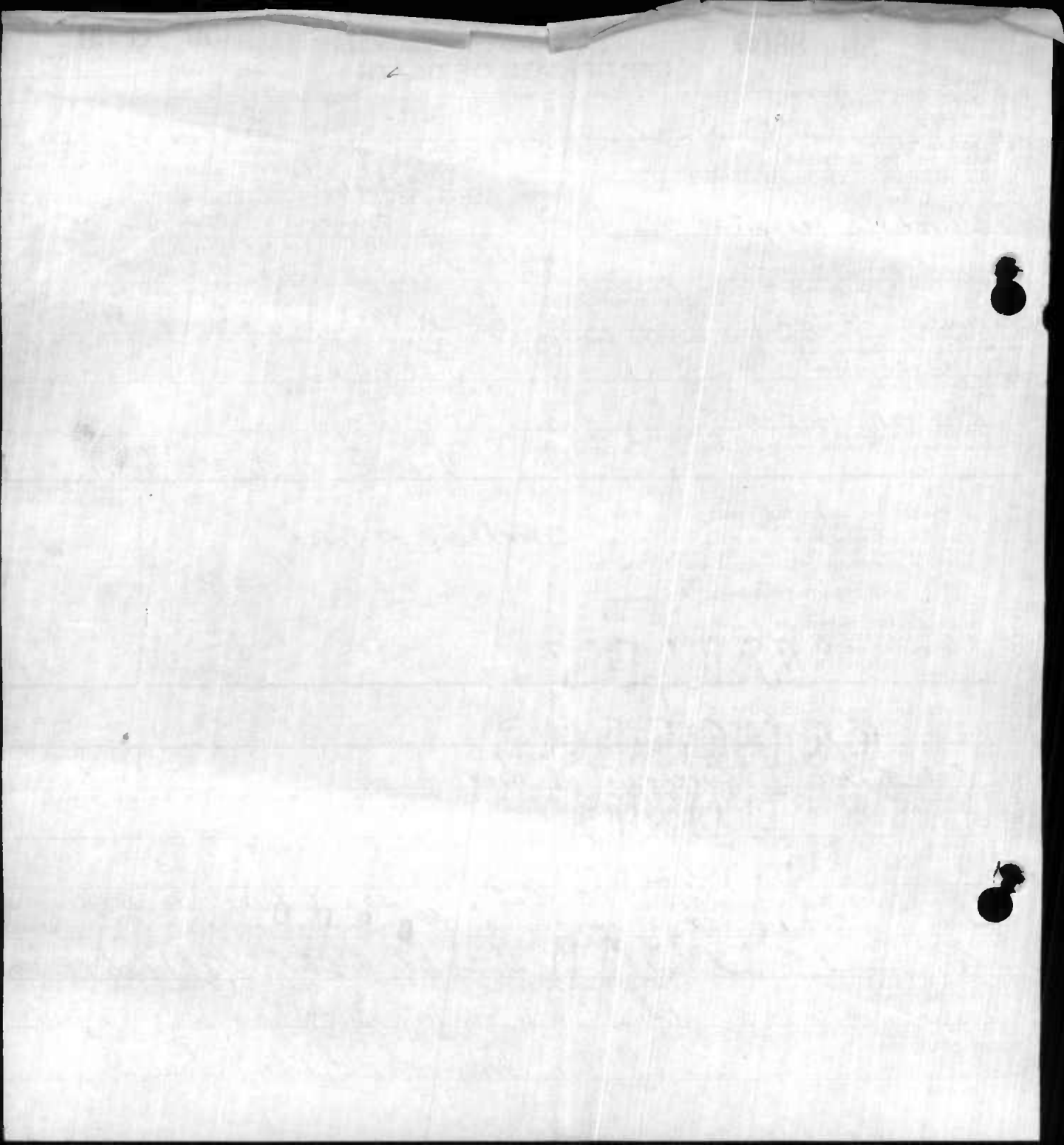
25. FUNERAL DIRECTOR

ADDRESS

*Oct 15 1950*

*Wm. J. Williams, M.D.*

*Wm. Cook Jr. 1217 St. Paul St.*





MINISTRE OF HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

STATE OF DEATH



5-200  
50 8802BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8802  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Louis J. SACKS

2. DATE  
OF  
DEATH

10-13-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

3806 Woodhaven Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give

Baltimore 15-38 township)

D. STREET ADDRESS (If rural, give location)

3806 Woodhaven Ave

Length of stay in Baltimore

60 Yrs.  
Mons  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

male

white

widowed

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR

INDUSTRY

Retired

Coal Dealer

13. FATHER'S NAME

not known

11. BIRTHPLACE (State or foreign country)

Latvia

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Bertha Laynor -

same

18. 332X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

Cerebral Thrombosis

5 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

Arteriosclerosis

1 yr

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1940 to Oct. 12, 1950 that I last saw the  
deceased alive on Oct 12, 1950, and that death occurred at 7 A.m., from the causes and on the date stated above.

23A. SIGNATURE

Irvin Barber M. D.

23B. ADDRESS

3003 Garrison Rd

23C. DATE SIGNED

10-13-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

10-15-50

Beth T. Filsh

Balto, Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 15 1950

J. B. Lawrence

2100 Cutaw Pl

VS 150

08313

House of Representatives

January 1, 1900

Washington, D.C.

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 29th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully,  
Your obedient servant,

John D. Smith

Secretary of the Interior

Department of the Interior

Washington, D.C.

Very respectfully,  
John D. Smith

Secretary of the Interior

Department of the Interior

Washington, D.C.

Very respectfully,  
John D. Smith

Secretary of the Interior

Department of the Interior

Washington, D.C.

Very respectfully,  
John D. Smith

Secretary of the Interior

Department of the Interior

Washington, D.C.

M-456

50 8803

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

DAVID MILNER

2. DATE  
OF  
DEATH

10-14-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

3531 Oakmont Ave Baltimore 27-18

D. STREET ADDRESS (If rural, give location)

3531 Oakmont Ave

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

Male

White

Married

56

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Merchant

10B. KIND OF BUSINESS OR  
INDUSTRY

Gen. Merchandise

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Solomon

14. MOTHER'S MARRIED NAME

Catherine

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mary Milner -

Same

18. 153x

CAUSE OF DEATH

Carcinoma of Colon

INTERVAL BETWEEN  
ONSET AND DEATH

1 year

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

none

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from Sept 1, 1949, to Oct 14, 1950, that I last saw the  
deceased alive on Oct 14, 1950, and that death occurred at 12:30 a.m., from the causes and on the date stated above.

23. SIGNATURE

Harold Levin

M. D.

23B. ADDRESS

4818 Reisterstown Rd

23C. DATE SIGNED

Oct 24/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 15 1950

Wilmington Delaware

2100 Eutan Rd

VS 150

2906C

0462

MEDICAL CERTIFICATION

11-11-55

11-11-55

11-11-55

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

5-420  
50 8804

## BALTIMORE CITY HEALTH DEPARTMENT

50 8804

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>John Scales</i>		2. DATE OF DEATH <i>Oct 13 '50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>		C. CITY OR TOWN <i>Balto</i> (If inside corporate limits, write RURAL and give township)	
6. LENGTH OF STAY IN BALTIMORE <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>1416 E. Lafayette Ave</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>10-29-1889</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steamfitter</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>60</i> Under 1 Year Months: Days Hours: Min.
11. BIRTHPLACE (State or foreign country) <i>Balto Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Stephen Scales</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Connelly</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-14-0048</i>	
17. INFORMANT <i>Mrs. Jessie E. Scales</i>		ADDRESS <i>--1416 E. Lafayette Ave</i>	

18. <i>442x</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) <i>Pulmonary Edema</i> DUE TO (B) <i>Cerebral-vascular accident</i> DUE TO (C) <i>Hypertensive Cardiovascular Disease</i>	INTERVAL BETWEEN ONSET AND DEATH <i>Oct 11</i> <i>to Oct 13</i>
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II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
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19A. DATE OF OPERATION <i>NO</i>	19B. MAJOR FINDINGS OF OPERATION <i>NO</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Oct 9*, 19*50*, to *Oct 13*, 19*50*, that I last saw the deceased alive on *Oct 13*, 19*50*, and that death occurred at *2:28* P.m., from the causes and on the date stated above.

23A. SIGNATURE <i>Frank P. Rasik</i>	23B. ADDRESS <i>3630 Elkader Rd</i>	23C. DATE SIGNED <i>10/13/50</i>
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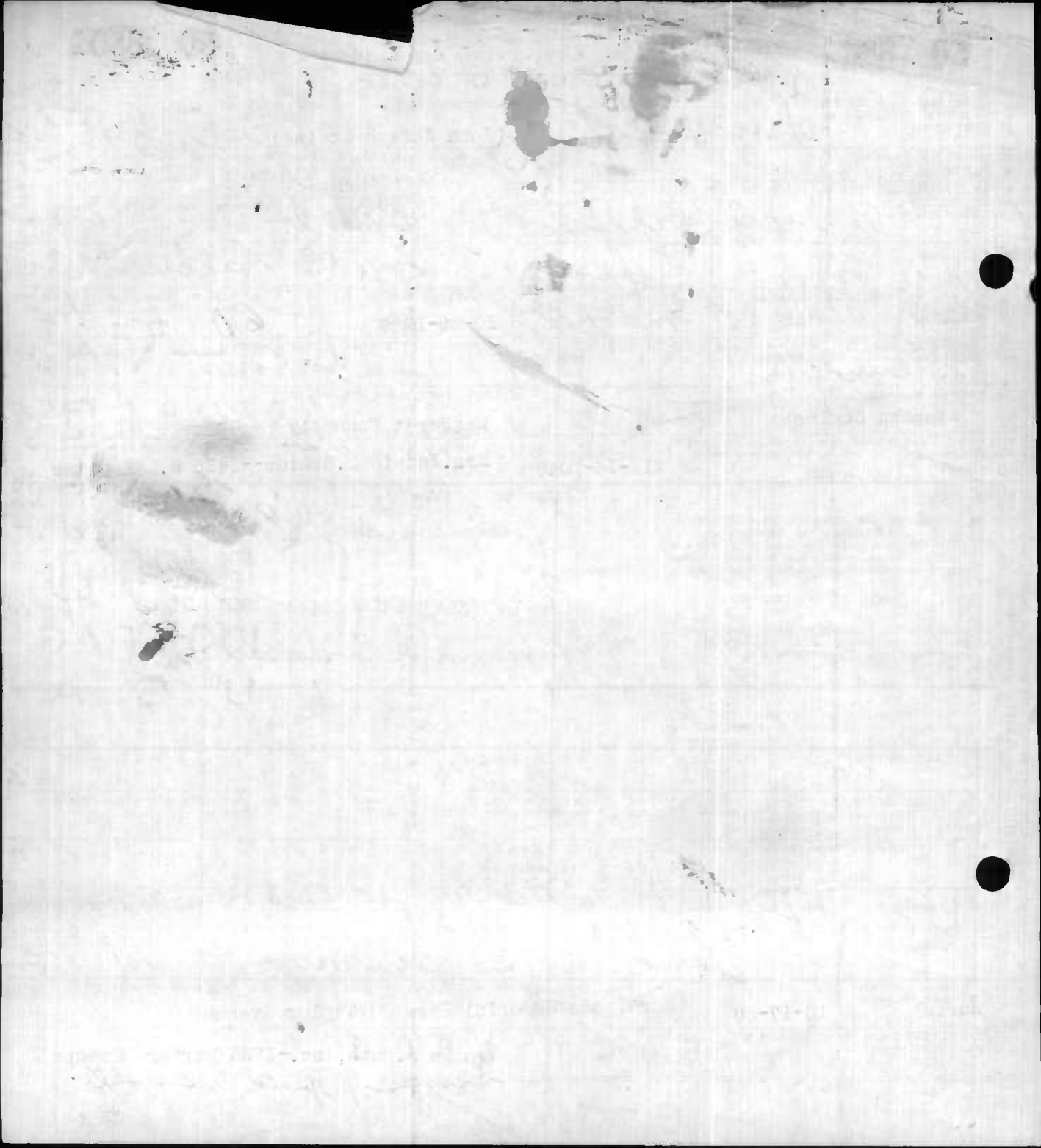
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>10-17-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Morelands Memorial Park</i>	24D. LOCATION (City, town, or county) (State) <i>Taylor Avenue</i>
---	---------------------------	---	--

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>George J. Ruth, Inc.</i>	25. FUNERAL DIRECTOR <i>George J. Ruth, Inc.</i>	ADDRESS <i>-1735 Harford Avenue</i>
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VS 150  
OCT 15 1950

57424

092d





G-426

50 8805

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8805

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH B GALLAGHER

2. DATE  
OF  
DEATH

Oct. 13, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

1500 E. Fort Ave

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto

24-01

D. STREET ADDRESS (If rural, give location)

1500 E Fort Ave

c. Length of stay in Baltimore

66

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

May 26

9. AGE (in years last birthday)

66

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

OWNER

10B. KIND OF BUSINESS OR INDUSTRY

CONFECTIONERY (R)

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Gallagher

14. MOTHER'S MAIDEN NAME

Mary Stevens

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Phyllis Gallagher 1500 E Fort Ave

18.

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

coronary embolism

arterio sclerosis

hypertension

chronic interstitial

1/2 h

1/2 h

1/2 h

1/2 h

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

pressure of eye due to exophthalmos 5mo

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 13, 1950, to Oct. 13, 1950, that I last saw the deceased alive on Oct 12, 1950, and that death occurred at 11 a.m., from the causes and on the date stated above.

23A. SIGNATURE

J. F. A. Stevens

23B. ADDRESS

2878 Harford St

23C. DATE SIGNED

10-14-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-16-50

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

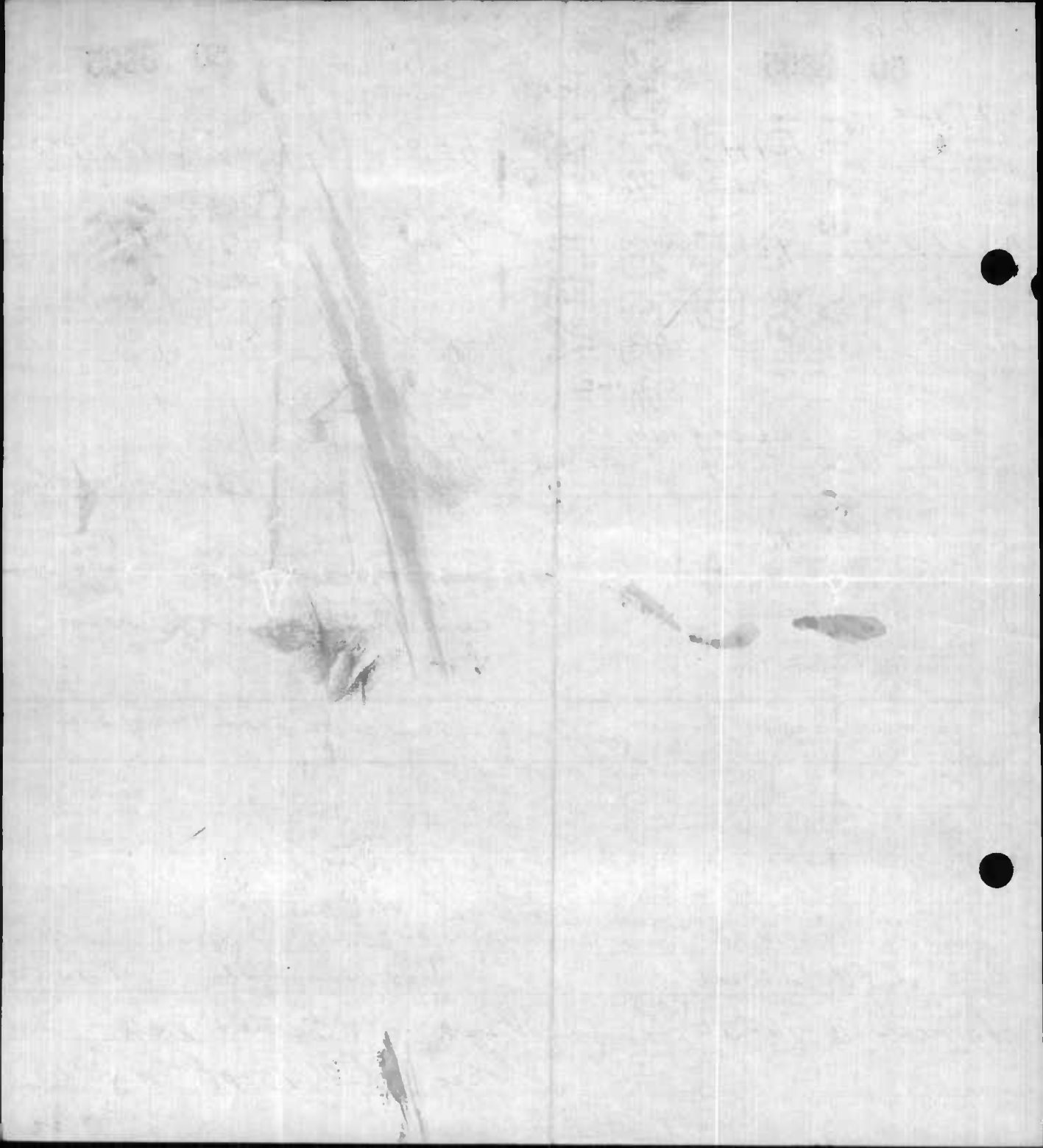
Chas. F. Del 1500 E Fort Ave

VS 151950

2906A

131a

MEDICAL CERTIFICATION



-452  
50 8806BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8806

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Frances Catherine Williams</i>			2. DATE OF DEATH <i>10-13-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore City</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Hospital for the Women of Maryland.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>8-65</i>		
5. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>1643 DARLEY AVE.</i>		
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>July 28, 1901</i>	9. AGE (in years last birthday) <i>49</i>	10. UNDER 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife.</i>			11. BIRTHPLACE (State or foreign country) <i>Philadelphia, Pa.</i>		
10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Julius Drost.</i>			14. MOTHER'S MAIDEN NAME <i>Catherine Drost-Reinhold.</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>?</i>			16. SOCIAL SECURITY NO. <i>?</i>		
17. INFORMANT <i>Deceased.</i>			ADDRESS		

## CAUSE OF DEATH

18. <i>443X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(A) <i>Cerebral vascular accident</i> DUE TO (B) <i>Hypertensive Cardiovascular Disease</i> DUE TO (C) <i>—</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2-3 hours (?)</i> <i>? no. years.</i>
---	---	---

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <i>None.</i>		19B. MAJOR FINDINGS OF OPERATION <i>—</i>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>—</i>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>—</i>	
22. I hereby certify that I attended the deceased from <i>Oct. 9</i> , 19 <i>50</i> , to <i>Oct. 13</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Oct. 12</i> , 19 <i>50</i> , and that death occurred at <i>6 15/4</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS <i>Hosp. for Women of Md.</i>		23C. DATE SIGNED <i>Oct 15 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/16/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>		25. FUNERAL DIRECTOR <i>L. Luck</i>		ADDRESS <i>5305 Norford Rd</i>	

VS 150

093d

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. The text is mostly mirrored and difficult to decipher.]*

130 50 8807

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8807  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Hazel Reffitt

2. DATE  
OF  
DEATH

10/15/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

St Agnes Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

7-5-1918

9. AGE (In years  
last birthday)

32

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

S. M. White

14. MOTHER'S MAIDEN NAME

Pearl

36664

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mr. Charles E. Reffitt 114 Jeffry St.

18. 340.3

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Overwhelming Toxemia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Meningitis of Unknown

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Etiology of  
Pregnancy

over

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK

22. I hereby certify that I attended the deceased from 9/29, 1950, to 10/15, 1950 that I last saw the deceased alive on 10/15, 1950, and that death occurred at 8:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

John C. Healy

M. D.

St. Agnes Hospital

10/15/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Removal

Oct. 15 1950

Russell Ky.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 16 1950

William J. Dickner

William J. Dickner &amp; Sons

Stillbirth # 36664 - 10/15/50.



50 8808

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8808

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Arthur H. Owens

2. DATE  
OF  
DEATH

October 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Maryland General Hospital

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Maryland General Hospital

Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life even if retired)

Merchant

10B. KIND OF BUSINESS OR  
INDUSTRY

Retail

13. FATHER'S NAME

Elmore Owens

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

9/25/68

9. AGE (In years  
last birthday)

82

11. BIRTHPLACE (State or foreign country)

Perryville, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

14. MOTHER'S MAIDEN NAME

Mary Jane

17. INFORMANT

ADDRESS

Ella M. Owens (wife) Perryville, Md.

18. 541.0

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

arterio-sclerotic cardiovascular disease

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from September 21, 1950, to October 15, 1950, that I last saw the  
deceased alive on October 15, 1950, and that death occurred at 4:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

M. A. White Lounia andrews

23B. ADDRESS

Maryland General Hospital

23C. DATE SIGNED

October 15, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

9-18-1950

24C. NAME OF CEMETERY OR CREMATORY

St. Lawrence

24D. LOCATION (City, town, or county)

Cathlamet, Md. 9710

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

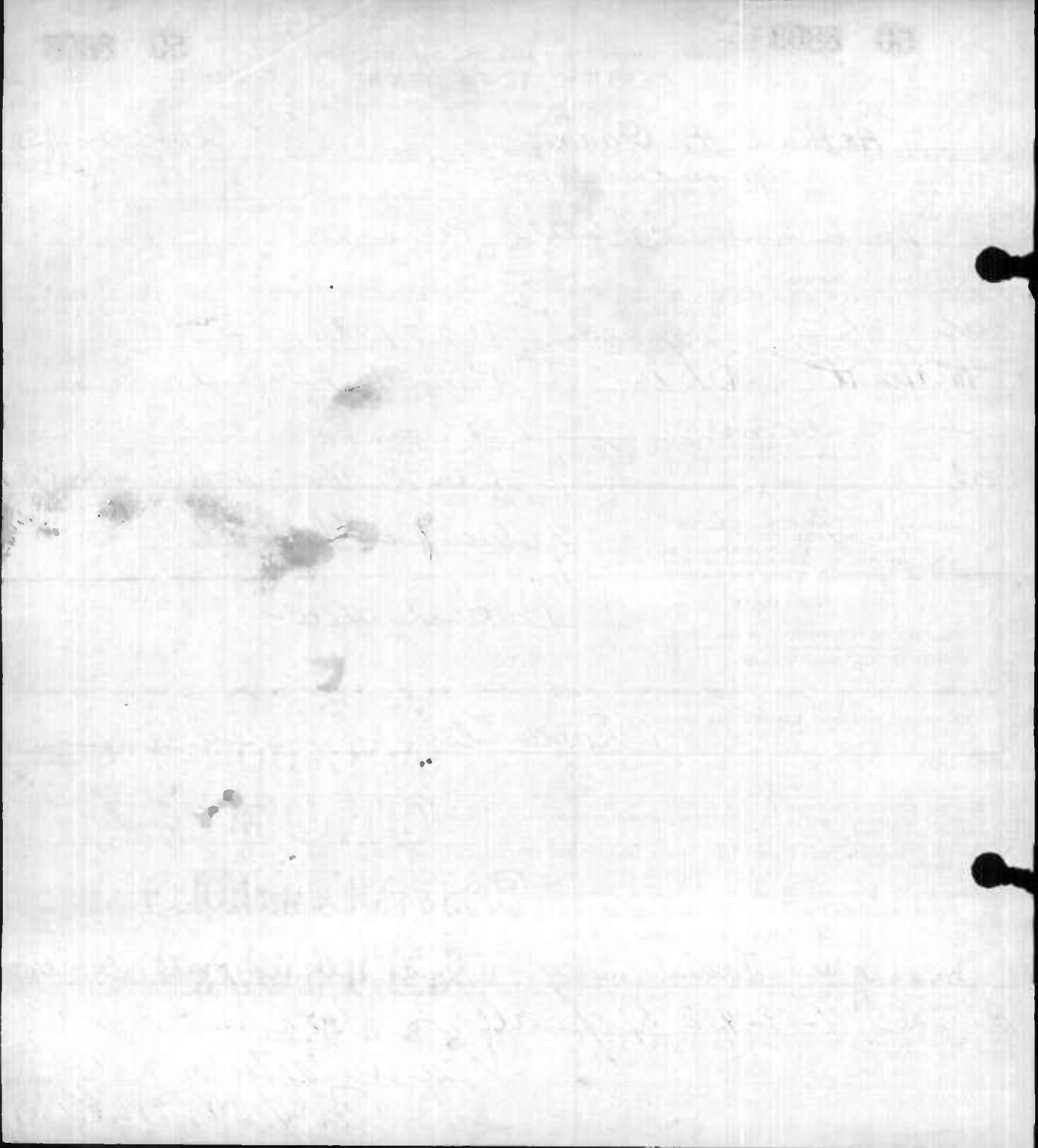
W. A. Patterson

25. FUNERAL DIRECTOR

W. A. Patterson &amp; Son

ADDRESS

131. a Perryville, Md.



H-300 50 8809

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 8809

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HEWITT, LYNWOOD C.

2. DATE  
OF  
DEATH

10-15-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
A. STATE B. COUNTY before admission)

Va

NORFOLK

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

U.S. MARINE HOSP. BALTO, MD.

C. CITY OR TOWN

NORFOLK

(If outside corporate limits, write RURAL and give township)

V-43

D. STREET ADDRESS (If rural, give location)

3400 VERDUN AVE.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Mar 13, 1899

9. AGE (In years;  
last birthday)

51

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Mechanist

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Miles Hewitt

14. MOTHER'S MAIDEN NAME

Laura Murrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 163X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Carcinoma of Lung

11 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 17, 1950, to Oct 15, 1950, that I last saw the  
deceased alive on Oct 14, 1950, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

A.O.D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Removal

24B. DATE

Oct 15th 1950

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

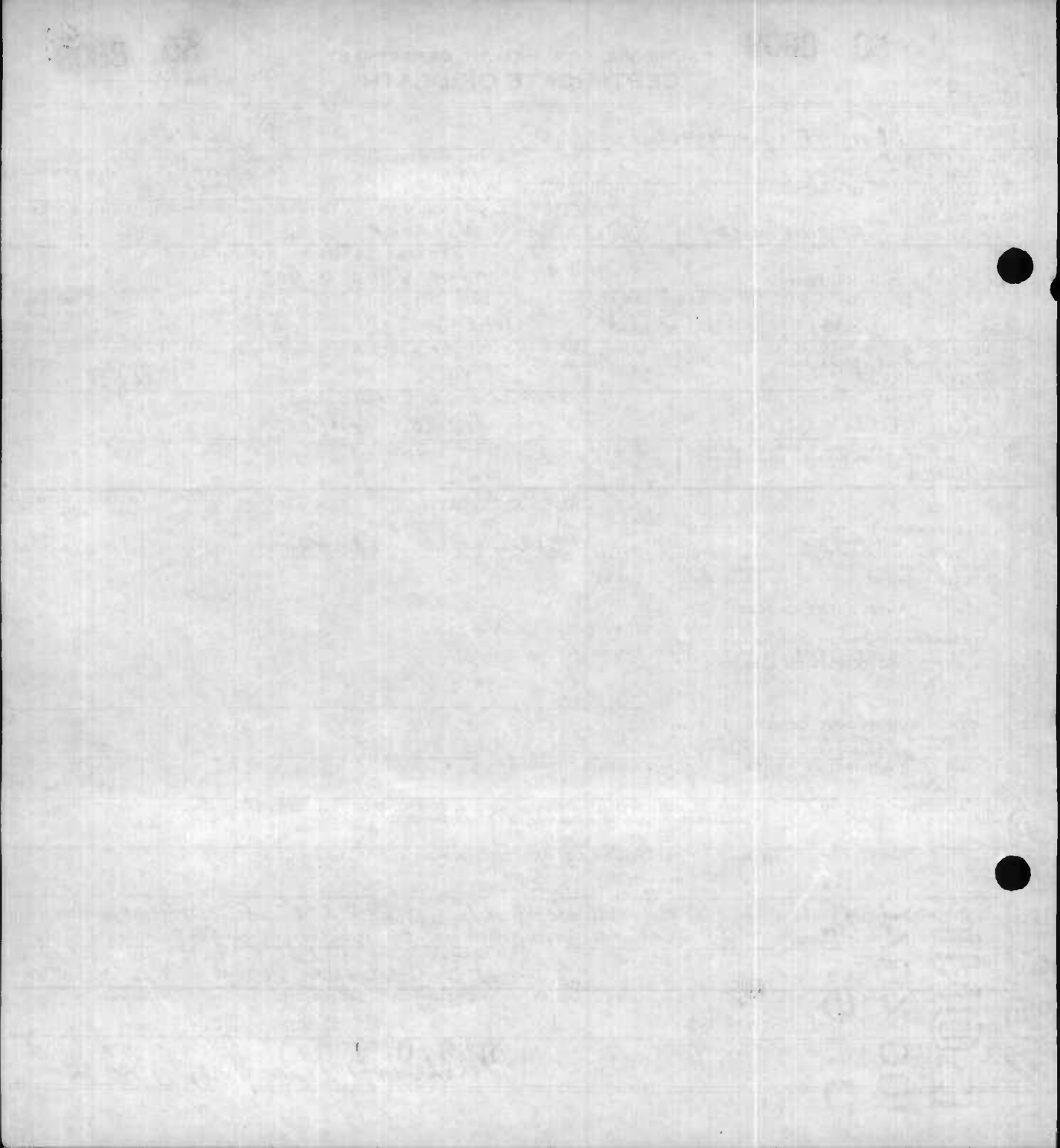
Richmond Va.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



50 8810

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8810

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

RUTH LUCILLE WINDESHEIM

2. DATE  
OF  
DEATHOct. 14<sup>th</sup> 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Doctors Hospital

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

Ch

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

PSALTO

Pembroke Ave

D. STREET ADDRESS (If rural, give location)

4914 Pembroke Ave 27-17

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

June 30<sup>th</sup> 1917

9. AGE (In years-

last birthday)

33 1/2

10. Under 1 Year

Months: Days

3 14

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

John Barrie

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Lydia Morris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Henry James Windesheim 4914 Pembroke Ave

ADDRESS

18. 584X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Respiratory failure  
Cerebral accident

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

10/14/50

19B. MAJOR FINDINGS OF OPERATION

Gall Bladder with stones

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1950 to Oct. 14, 1950 that I last saw the deceased alive on Oct. 14, 1950 and that death occurred at 4 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Henry S. Barrie

M. D.

23B. ADDRESS

2128 W. North Ave

23C. DATE SIGNED

Oct 15 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

Oct 17 1950

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Burial Society

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

OCT 16 1950

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

David Soudien &amp; Son 1902 Euteria Pl

ADDRESS

NO 8110

NO 8110

CERTIFICATE OF DEATH

1 11

*[Faint, illegible handwriting]*



253 50 8811

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8811

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EDWARD SIDNEY ROSENTHAL</b>			2. DATE OF DEATH <b>Oct. 14<sup>th</sup> 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>4023 Barrington Rd</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>- Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
5. Length of stay in Baltimore <b>lifetime</b>			D. STREET ADDRESS (If rural, give location) <b>4023 Barrington Rd 15-10</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>Feb 6<sup>th</sup> 1901</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Year Months: <b>7</b> Days: <b>8</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Traveling Salesman</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Slacks</b>		
11. BIRTHPLACE (State or foreign country) <b>Balto Md</b>			12. CITIZEN OF WHAT COUNTRY? <b>+</b>		
13. FATHER'S NAME <b>Sidney Joseph Rosenthal</b>			14. MOTHER'S MAIDEN NAME <b>Emily Goldsmith</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Family -</b>			ADDRESS <b>4023 Barrington Rd</b>		

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>	CAUSE OF DEATH <b>Coronary atherosclerosis</b>	INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Coronary atherosclerosis</b>	(B) <b>Coronary atherosclerosis</b>	<b>sync</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 13</b> 19 <b>45</b> , to <b>Oct 14</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>Oct 14</b> , 19 <b>50</b> , and that death occurred at <b>440</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Michael S. Fink</b>		23B. ADDRESS <b>2320 Eutaw Place</b>		23C. DATE SIGNED <b>10/15/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>Oct 16/1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HAR SINAI</b>	
24D. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR <b>David Schneiderman</b>		ADDRESS <b>1502 Eutan Pl</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>William J. Williams</b>		25. FUNERAL DIRECTOR <b>David Schneiderman</b>	

Do Mr. Kisch. 3.001 Garrison Blvd

UNITED STATES DEPARTMENT OF HEALTH

514  
50 8812BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8812  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Louise M. Schnebelen</b>		2. DATE OF DEATH <b>Oct. 14, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2445 Washington Boulevard</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 25-43</b>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>2445 Washington Boulevard</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>July 25, 1883</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	9. AGE (in years last birthday) <b>67</b> If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>A. A. County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Bolm</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Miers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Edward Schnebelen, 2445 Washington Blvd.</b>		ADDRESS	

18. **420.1**

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Crown artery occlusion**  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Hypertension Cardiovascular disease**  
DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **0**

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., to or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **Sept 23, 1950** to **Oct 14, 1950**, that I last saw the deceased alive on **Oct 10, 1950** and that death occurred at **3 a. m.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)  
**burial**

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1944 03

1944 02

STATION OF THE

NO. 1000

1944

1944

1944

1944

1944

1944

1944

1944

1944

50 8813 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

Registered No. 50 8813

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Ross E Taylor</i>		2. DATE OF DEATH <i>10-13-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Catonsville 5200</i>	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>Old Frederick &amp; Academy Rds-</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>12/10/1882</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter &amp; Painter</i>		9. AGE (in years last birthday) <i>67</i>	
10B. KIND OF BUSINESS OR INDUSTRY <i>Building</i>		11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md.</i>	
13. FATHER'S NAME <i>Kinsey R. Taylor</i>		12. CITIZEN OF WHAT COUNTRY?	
14. MOTHER'S MAIDEN NAME <i>Mary C. Smith</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Edith Taylor Catonsville Md</i>	

18. <i>420.1 181X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Ventricular Fibrillation</i> DUE TO (B) <i>Previous Coronary Occlusion</i> DUE TO (C) <i>Generalized Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>3 yrs</i> <i>Indefinite</i>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Carcinoma of the Bladder</i>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <i>10-13-50</i>	19B. MAJOR FINDINGS OF OPERATION <i>Carcinoma of the Bladder</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>9-7</i> , 1950, to <i>10-13</i> , 1950, that I last saw the deceased alive on <i>10-13</i> , 1950, and that death occurred at <i>10:15 AM.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>Henry L. James, Jr.</i>	23B. ADDRESS <i>University Hospital</i>	23C. DATE SIGNED <i>10-13-50</i>
24A. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>10/16/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Carrollton Church of God</i>
24D. LOCATION (City, town, or county) (State) <i>Carroll Co. Md.</i>	25. FUNERAL DIRECTOR <i>Wm. Cook Inc.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 16 1950</i>	REGISTRAR'S SIGNATURE <i>Washington Hill</i>	ADDRESS <i>1217 St. Paul St.</i>

51024

0526

DATE 02

DATE 02

WILLIAM

1983



50 8814

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8814

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BENJAMIN KILGOUR

2. DATE  
OF  
DEATH

October 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2013 E. Fayette St

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto. 6-04

D. STREET ADDRESS (If rural, give location)

2013 E. Fayette St.

5. SEX

M

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1/6/1893

9. AGE (In years  
last birthday)

57

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

Buffer &amp; Polisher Brown Co. &amp; Seal Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

(Unknown) Kilgour

14. MOTHER'S MAIDEN NAME

(Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Annie Kilgour 2013 E. Fayette St.

18. 463X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Pulmonary embolism

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Thrombophlebitis of rt. leg.

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection and Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley B. Dunleavy M.D.

23B. CHIEF MEDICAL EXAMINER ☐ 23C. DATE SIGNED  
ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ Oct. 15, 1950.24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town or county) (State)

Burial

10/18/50

Parkwood

Parkville Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

10/17/50

Eutaw M. Williams

1014 E. 1217 St. Paul St.

1983 02

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

1983 02

50 8815

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8815

Registered No. 3698

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William W. Curry

2. DATE  
OF  
DEATH

Oct. 13/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

16-01

D. STREET ADDRESS (If rural, give location)

632 N. Carrollton Ave

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

E. Length of stay in Baltimore

35

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

July 10-1894

9. AGE (in years last birthday)

56

If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY

Steel Labor

11. BIRTHPLACE (State or foreign country)

Edwardsville Va

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Wesley Curry

14. MOTHER'S MAIDEN NAME

Mary E. Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

No. No. 1

16. SOCIAL SECURITY NO.

216-10-5607

17. INFORMANT

ADDRESS

Pearl Curry - 632 N. Carrollton Ave

18.

422.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Myocarditis

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

one year

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

arteriosclerosis

DUE TO

unknown

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-15, 1950, to 10-13, 1950, that I last saw the deceased alive on 10-13, 1950, and that death occurred at 12:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Frank A. Saunders

23B. ADDRESS

1029 N. Stricker St

23C. DATE SIGNED

10-17-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

10/17/50

24C. NAME OF CEMETERY OR CREMATORY

White Mt. Park

24D. LOCATION (City, town, or county)

Baltimore Co.

(State)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William W. Curry

25. FEDERAL DIRECTOR

ADDRESS

Samuel W. Sullivan Jr

VS 150

940 55

1011 N. Arlington Ave 093d

MEDICAL CERTIFICATION

W. A. W.

C. A. W.

J. A. W.

M. A. W.

A. A. W.

300 50 8816

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>CAROLINE P. SCHOTTA</b>			2. DATE OF DEATH <b>10-14-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>md.</b> B. COUNTY <b>Balto.</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>HOOD'S NURSING HOME</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore Catonsville</b>		
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>6612 Greenock Drive</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>June 27, 1862</b>		9. AGE (In year, last birthday) <b>88</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>William Schuering</b>			14. MOTHER'S MAIDEN NAME <b>Susan Coleman</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT ADDRESS <b>Mrs. H. Marie Hawkins-6612 Greenock Dr.</b>		

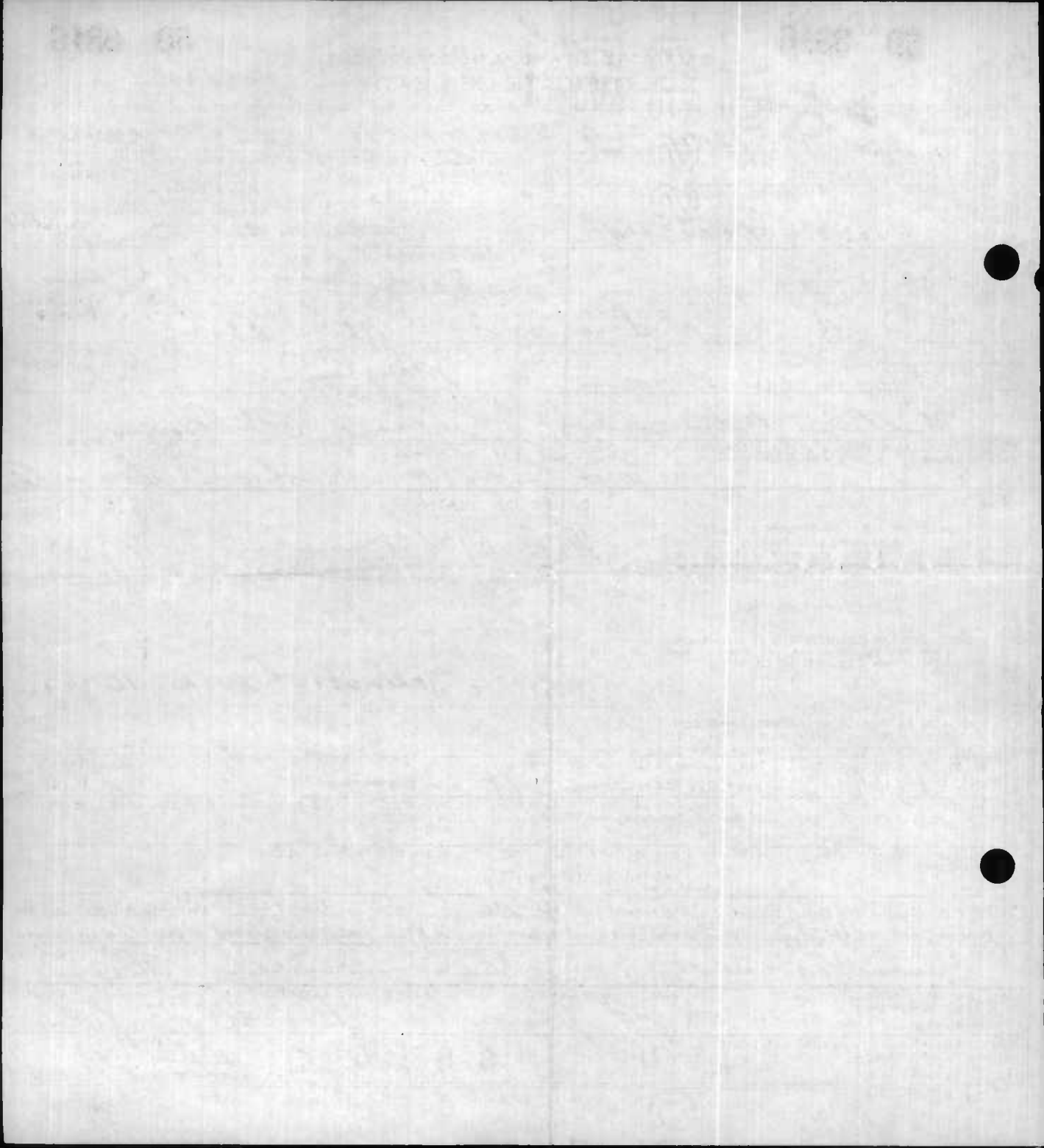
18. <b>194x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>I</b> <b>P. A. of uterus</b> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>(C) Acute Salivary G. V. D. 10 yrs</b>	

19A. DATE OF OPERATION <b>1949</b>	19B. MAJOR FINDINGS OF OPERATION <b>Carcinoma of uterus</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **5-16**, 19**50**, to **10-14**, 19**50**, that I last saw the deceased alive on **10-13**, 19**50**, and that death occurred at **2 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE <b>James G. Stowell</b>	23B. ADDRESS <b>Catonsville</b>	23C. DATE SIGNED <b>10-15-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-16-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>
24D. LOCATION (City, town, or county) <b>Ellicott City, Md.</b>		24E. LOCATION (State) <b>Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 16 1950</b>	REGISTRAR'S SIGNATURE <b>William H. ...</b>	25. FUNERAL DIRECTOR <b>George A. Farley</b>
		ADDRESS <b>Catonsville, Md.</b>

0486





50 8817

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8817  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

J. EARL Rowe

2. DATE  
OF  
DEATH

10-13-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

St. Agnes' Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 20-68

D. STREET ADDRESS (If rural, give location)

4207 Frederick Ave

5. SEX

M

6. COLOR OR RACE

Wh.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

5-8-1901

9. AGE (In years last birthday)

49

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Self-employed dentist

10B. KIND OF BUSINESS OR INDUSTRY

Dentist

11. BIRTHPLACE (State or foreign country)

Maine

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James A. Rowe

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, on or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs. J. Earl Rowe - 4207 Fred. Ave.

18.

415x I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

(A)

Rheumatic CVD

DUE TO

ANTECEDENT CAUSES

(B)

Myocardial Failure

DUE TO

(C)

Uremia

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10/12, 1950, to 10/13, 1950 that I last saw the deceased alive on 10/13, 1950, and that death occurred at 7:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

John C. Healy

M. D.

23B. ADDRESS

St. Agnes

23C. DATE SIGNED

10/13/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Walter J. Williams

L. J. Foley - Fulton Ave. &amp; Fayette St.

VS 150

03285

093C

MEDICAL CERTIFICATION

1028 32

1028 32

ST. LOUIS, MO. JANUARY 1901

RECEIVED

5 2 3

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. JOHN

1. NAME OF DECEASED  
(Type or Print)

JOHN FRANK MEANS

2. DATE  
OF  
DEATH

10-12-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

UNIVERSITY HOSPITAL

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND BALTO.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

DUNDALK

D. STREET ADDRESS (If rural, give location)

8200 DOGWOOD DRIVE

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

BARBER RET.

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

DAVID J. MEANS

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

14. MOTHER'S MAIDEN NAME

MARY MILES

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

A.R. MEANS 8200 DOGWOOD DR.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Uremia

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK AT WORK

22. I hereby certify that I attended the deceased from 9-29, 1950, to 10-12, 1950, that I last saw the deceased alive on 10-30, 1950, and that death occurred at 10:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

R.C. Spaulding

23B. ADDRESS

M. D.

Univ. Hosp.

23C. DATE SIGNED

10-13-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

OCT 16, 1950

OAK LAWN CEM.

BALTIMORE CO., MD.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. ...

ULLRICH FUNERAL HOME

VS 150

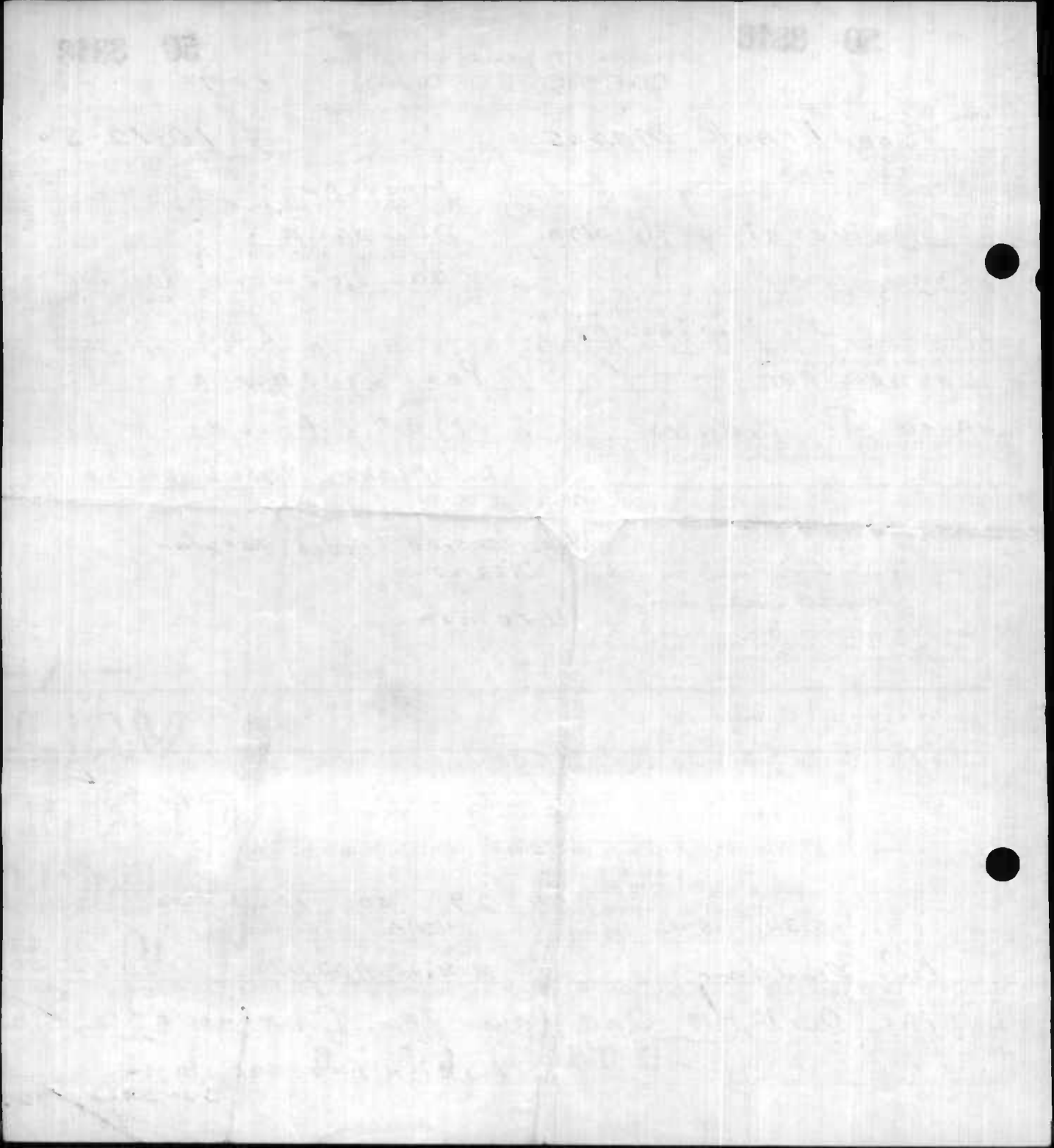
DUNDALK, MD.

0932

MEDICAL CERTIFICATION  
correct age is especially important. Physicians: please write the causes of death clearly and briefly.

30 3112

3112 30



50 8819

50 8819

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

CHARLES HENRY FRISBIE

2. DATE  
OF DEATH Oct. 13, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2236 Lake Ave.,

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTYB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 8-01

C. Length of stay in Baltimore Lifetime Yra. Mos. Days

D. STREET ADDRESS (If rural, give location)  
2236 Lake Ave.,

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Widowed

8. DATE OF BIRTH

Nov. 15, 1868

9. AGE (In years last birthday)  
81

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Police-retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Edgar G. Frisbie

14. MOTHER'S MAIDEN NAME

Lingenfelder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
No.

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Edgar L Frisbie 2236 Lake Ave.

18. 153X I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
DUE TO

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST.

(A) Carcinoma of large intestine 1 yr.  
(B)  
(C)II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
Generalized arteriosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from Jan 1942, to October 13, 1950, that I last saw the deceased alive on October 9, 1950, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct 16, 1950

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county) (State)

Baltimore

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 16 1950

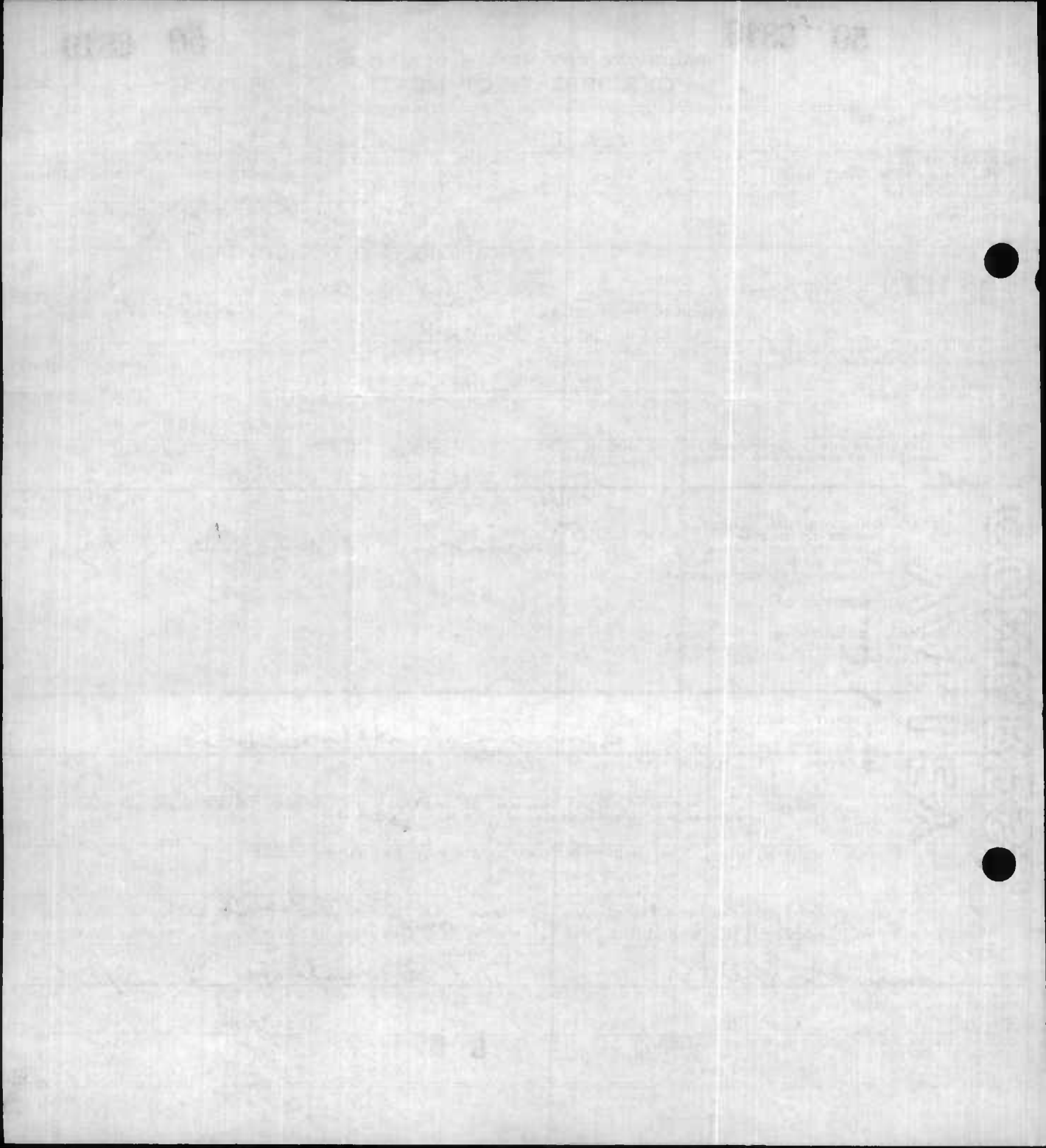
Washington Williams

Ullrich Funeral Home 2008 Orleans St.

VS 150

0462

MEDICAL CERTIFICATION





532  
50 8820BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8820  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		LITTLE LINDSAY		2. DATE OF DEATH Oct. 14, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-01			
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 947 Fitting St.			
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH ?? 1879	9. AGE (In years last birthday) 71	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Va	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ?			
14. MOTHER'S MAIDEN NAME Odessa?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no			
16. SOCIAL SECURITY NO. none		17. INFORMANT Mame Parker - 811 - Brodley			

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Anteriosclerotic Cardiovascular Disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH
--	--

19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE Stanley H. Dunsen M.D.	23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	23C. DATE SIGNED Oct. 14, 1950
--	---	-----------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE 10-17-50	24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn	24D. LOCATION (City, town, or county) (State) 0
DATE RECEIVED BY LOCAL REGISTRAR OCT 16 1950	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR W. Halstead	ADDRESS 918 Union Hill Ave.

8888

8888

8888

8888

8888

CERTIFICATE OF DEATH

1111

1111

1111

1111

1111



542  
50 8821BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 8821

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HERBERT KNOWLES

2. DATE  
OF  
DEATH

10-11-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)

A. STATE

B. COUNTY

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

630 GREENWILLOW STREET

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE 1. 17-02

c. Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

630 GREENWILLOW ST.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MALE

COLORED

MARRIED

8. DATE OF BIRTH

11-22-1903

9. AGE (In years  
last birthday)

46

10 Under 1 Year  
Months: Days Hours: Min.

9 21

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR  
INDUSTRY

GENERAL

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF  
WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

MACKIE KNOWLES

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

PEARL KNOWLES-630 GREENWILLOW ST.

18. 491X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Bronchopneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Malnutrition

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐22. I hereby certify that I attended the deceased from 10-5-1950 to 10-11-1950, that I last saw the  
deceased alive on 10-11-1950, and that death occurred at 11:59 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

10-16-50

MT. CALVARY

A. A. Co. Maryland.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 16 1950

Wm. A. JACKSON - 916 PENNA. AVE.

VS 150

97099

107.0

MEDICAL CERTIFICATION

STATE OF CALIFORNIA

VALLEY

COGNAC

CHAMPAGNE

COGNAC

CHAMPAGNE

# Medical Examiner's Case

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Solomon Scherr*

2. DATE  
OF  
DEATH

*10-15-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Sinai Hospital*

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

*Md*

B. COUNTY

*27-16*

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*Sinai Hospital*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Baltimore*

D. STREET ADDRESS (If rural, give location)

*4613 Park Heights Ave*

c. Length of stay in Baltimore

*16* Yrs.  
Mos.  
Days

5. SEX

*male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Widowed*

8. DATE OF BIRTH

9. AGE (In years)

If Under 1 Year: Months: Days: Hours: Min.

*74*

10A. USUAL OCCUPATION (Give kind of work done during working life, even if retired)

*Retired*

10B. KIND OF BUSINESS OR INDUSTRY

*Tailor*

11. BIRTHPLACE (State or foreign country)

*Russia*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Samuel*

14. MOTHER'S MAIDEN NAME

*not known*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
*Samuel Scherr - 2803 Mt Holly*

18. *E902.7*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

*Coronary occlusion*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

*Fractured right Femur*

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

CERTIFICATION APPROVED BY  
*DR. C. J. LUBINSKI*  
*per: B. B. Fisher M.D.*  
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION

*None*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

*Accident*

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

*Levindale Home*

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

*Levindale Home*

*27-17*

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

*10-2-50*

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

*Fell down from chair while arising*

22. I hereby certify that I attended the deceased from *10-2-50*, 19*50*, to *10-15-50*, 19*50*, that I last saw the deceased alive on *10-15-50*, 19*50*, and that death occurred at *6:30 P.M.*, from the causes and on the date stated above.

23A. SIGNATURE

*Joseph Louis Feingold*

23B. ADDRESS

*Sinai Hospital*

23C. DATE SIGNED

*10-15-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*10-16-50*

24C. NAME OF CEMETERY OR CREMATORY

*Beth T. Telok*

24D. LOCATION (City, town, or county)

*Balt. Md*

DATE RECEIVED BY LOCAL REGISTRAR

*OCT 16 1950*

REGISTRAR'S SIGNATURE

*Jack Lewis*

25. FUNERAL DIRECTOR

*Jack Lewis 2100 East Ave*

ADDRESS

VS 150

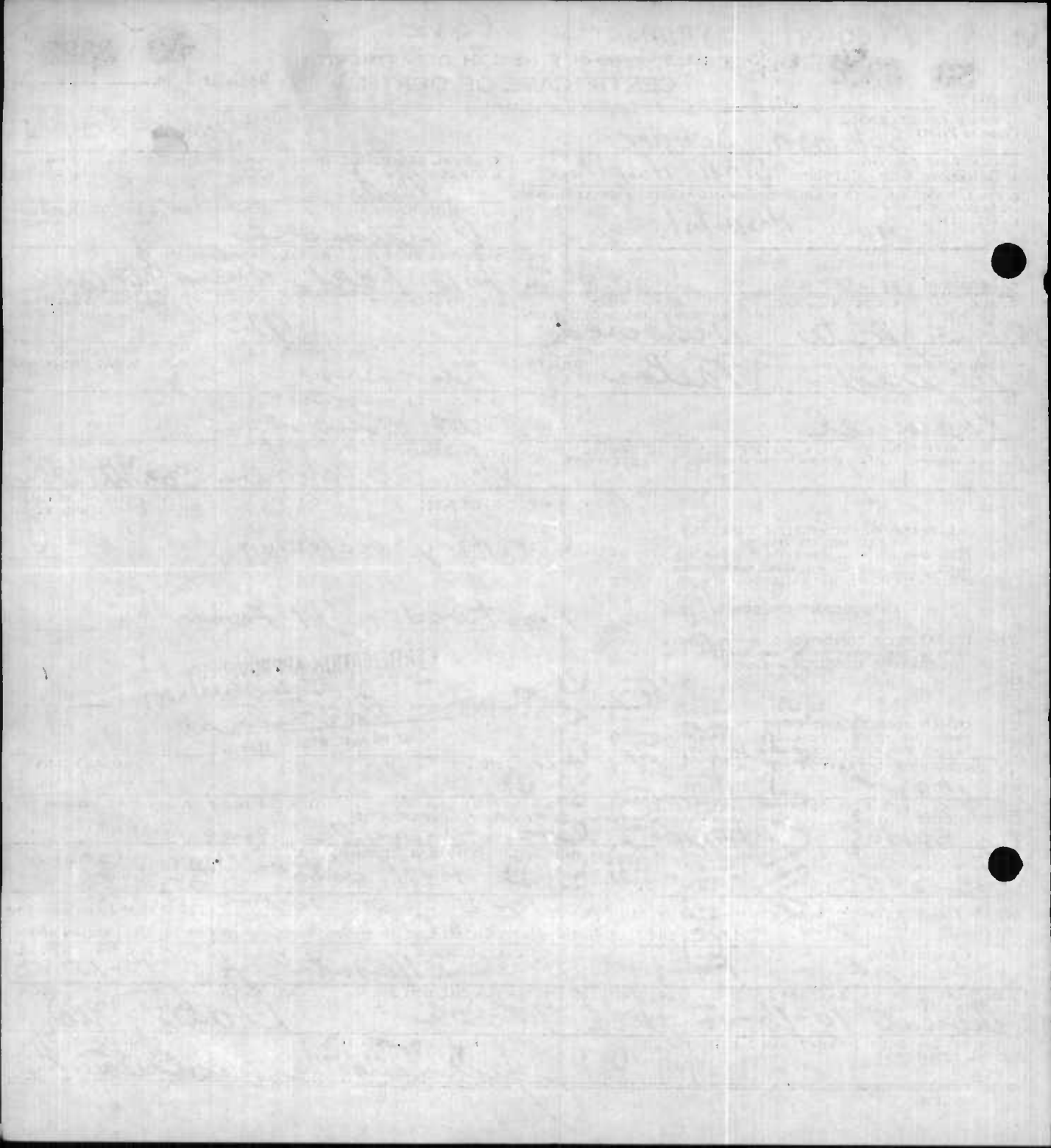
*N 821.0*

*5906E*

*186a*

MEDICAL CERTIFICATION

correct age is especially important. In all entries, please write the cause of death clearly and





620  
50 8823BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8823

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

NATHAN BERKOW

2. DATE  
OF  
DEATH

10-14-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Temple Gardens

C. Length of stay in Baltimore

60 Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore 13-01  
Temple Gardens apt 805

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9. AGE (in years last birthday)

11 Under 1 Year Months: Days

12 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)

Merchant

10B. KIND OF BUSINESS OR INDUSTRY

Wholesale Notions Russia

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph

14. MOTHER'S MAIDEN NAME

Minnie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Jennie Berkow - Same

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

Coronary Thrombosis 10 hours

Degenerative Cardio-vas. ?

Cancer Disease associated with Arteriosclerosis and hypertension

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

II

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from

deceased alive on 10-14-1950 and that death occurred at 10:00 p.m., 10-14, 1950 that I last saw the

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 16 1950

Arlington Williams

Jack Lewis Inc - 2100 Eutan PL

Summary

86150W

325  
50 8824BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8824  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>William H. ATKINSON</i>		2. DATE OF DEATH <i>10/12/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <i>St. Joseph's Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 26-03</i>	
Length of stay in Baltimore <i>life</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>3227 Pelham Ave.</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>Aug. 28, 1901</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sergeant, Police Dept.</i>		9. AGE (In years last birthday) <i>49</i>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
13. FATHER'S NAME <i>William K. Atkinson</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Thompson</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Wm. T. Atkinson</i>	
		ADDRESS <i>3227 Pelham Ave.</i>	

18. *420.1*

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

*Coronary Occlusion*

## ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspection Inquiry* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*John R. Davis*

M.D.

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

*10/13/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR  
*Oct 11 6 1950*

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

-13-

1078

03

1078

03

520 50 8825

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8825

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Louise H. Jones.

2. DATE  
OF  
DEATH

Oct. 12, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

809 N. Bruce St.

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 16-03

D. STREET ADDRESS (If rural, give location)

809 N. Bruce St

5. SEX

Female

6. COLOR OR RACE

C

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

B. DATE OF BIRTH

October 12, 1875-75

9. AGE (in years,

last birthday)

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

James Harris.

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Lillie Brydson, 809 N. Bruce St

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

DUE TO

Acute congestive heart failure

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

Hypertension, Atherosclerosis

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 21, 1950 to Oct. 12, 1950 that I last saw the deceased alive on Oct. 2, 1950, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

1612 Edmonson Ave.

10-14-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 16 1950

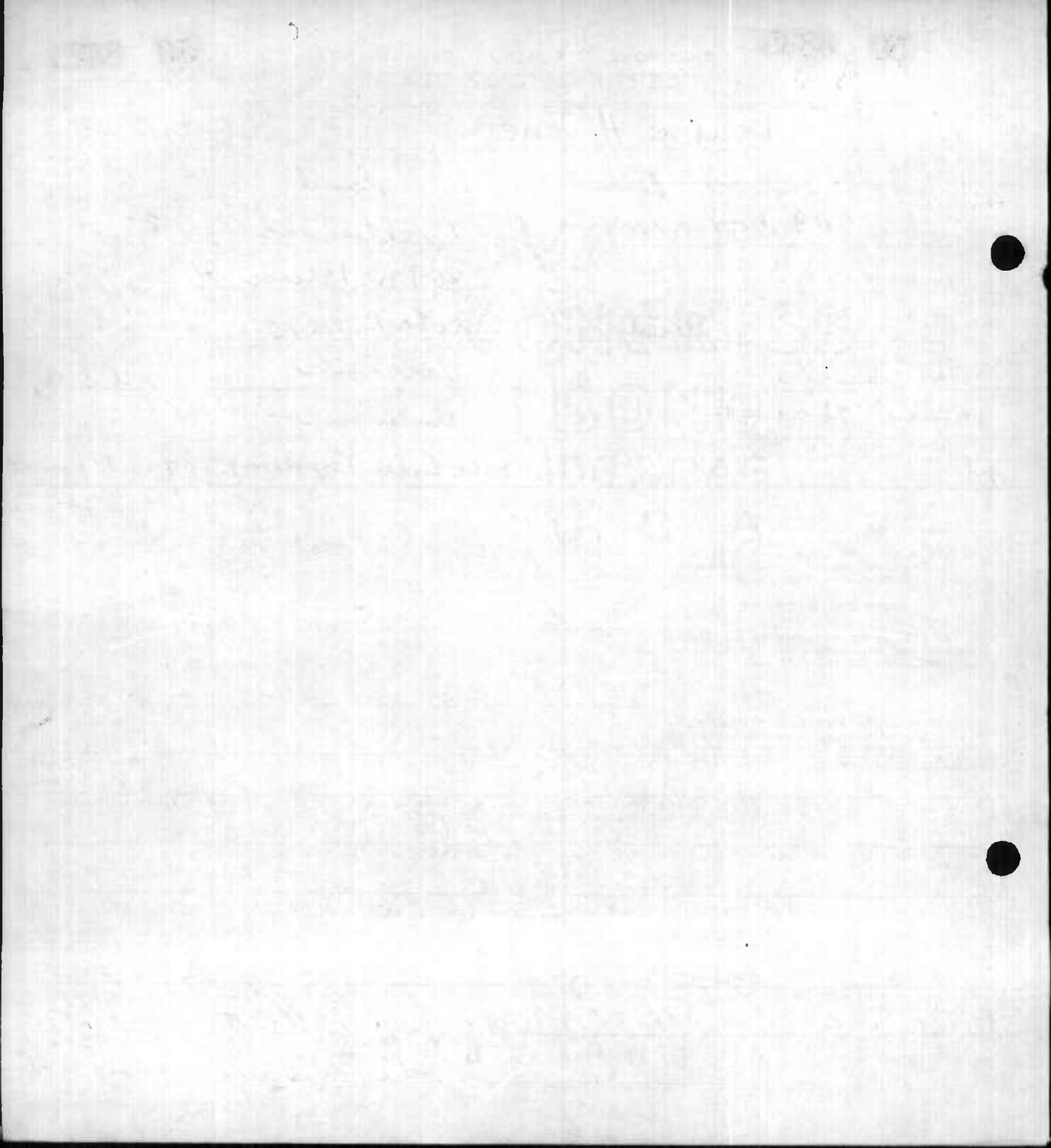
10-16-1950

Mt. Auburn Cem. Balto.

Md.

322 N. Sheward St

Miss Kate Williams





635 50 8826

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8826  
Registered No.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

BLANCHE MORTON

2. DATE

OF

DEATH October 13, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

a. STATE

b. COUNTY

before admission)

Maryland

c. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

14-03

d. STREET ADDRESS (If rural, give location)

2214 Etting Street

b. FULL NAME OF (If not in hospital or institution, give street address or location)

Provident Hospital

Yrs.

Mos.

Days

length of stay in Baltimore

5. SEX

female

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

6-5-1886

9. AGE (In years

last birthday)

64

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Maid

10b. KIND OF BUSINESS OR INDUSTRY

Hotel

11. BIRTHPLACE (State or foreign country)

Baltimore

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.C.

13. FATHER'S NAME

Jesse Campher

14. MOTHER'S MAIDEN NAME

Amelia Patterson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS 2214

Lexona Hall Etting St.

18. 443 X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Hypertensive and arteriosclerotic  
DUE TO cardiovascular disease

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)  
DUE TO  
(C)II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23a. SIGNATURE

Stanley H. Dunsicker

M.D.

23b. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒

23c. DATE SIGNED

Oct. 13, 1950

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 16 1950

10-16-1950

Mt. Calvary Comm. Center Hill Md.

3224

VS 151

7908B

Mrs. Kate R. Williams

Submerged

937

30 3038

30 3038

DEPARTMENT OF HEALTH

30 3038

30 3038

CERTIFICATE OF DEATH

NAME OF DECEASED

RESIDENCE OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF MINISTER

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NAME OF CLERGYMAN

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF MINISTER

NAME OF CLERGYMAN

520

50 8827

BALTIMORE CITY HEALTH DEPARTMENT

50 8827

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Belle Jones

2. DATE  
OF  
DEATH

Oct. 12, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

C. Length of stay in Baltimore

50 yrs

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMATION ADDRESS

18. 331X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular accident

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hemorrhage from right middle cerebral artery

DUE TO

(C) Hypertension

1 week

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary atelectasis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While at work ☐ Not while at work ☐

22. I hereby certify that I attended the deceased from 10/6 to 10/12, 1950, that I last saw the deceased alive on 10/12, 1950, and that death occurred at 7:05 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JOHNS HOPKINS HOSPITAL

Burial

10-16-50

Mt Calvary Cem A. A. Co

Md

OCT 16 1950

T. J. Sanders

Rayner Sanders 83a

1412 E. Preston St.

03

03

24/10

11

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **8828**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

**LOIS LYNN RICE**

2. DATE  
OF  
DEATH

**Oct. 15, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR US Marine Hospital  
INSTITUTION Wyman Pk. Drive & 31st St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Md.** B. COUNTY **Montgomery**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Chevy Chase**

D. STREET ADDRESS (If rural, give location)

**6500 Maple Avenue 6500**

Length of stay in Baltimore **58 days**

Yrs.  
Mos.  
Days

5. SEX

**F**

6. COLOR OR RACE

**W**

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
**Married**

8. DATE OF BIRTH

**1/7/92**

9. AGE (In years  
last birthday)

**58**

If Under 1 Year  
Months Days

If Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
**Housewife**

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Ohio**

12. CITIZEN OF  
WHAT COUNTRY?  
**USA**

13. FATHER'S NAME

**Francis Lee Goff**

14. MOTHER'S MAIDEN NAME

**Lula Lee Graves**

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) **No** (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO. **710**

17. INFORMANT ADDRESS  
**Records- US Marine Hospital, Balto, Md.**

18. **204.3**

**CAUSE OF DEATH**

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) **Acute leukemia**

DUE TO

**6 mos.**

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) **Hemorrhage, severe, into lungs**

DUE TO

**Recent**

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from **Aug. 18, 1950**, to **Oct. 15, 1950** that I last saw the  
deceased alive on **Oct. 15, 1950**, and that death occurred at **4:15 Pm.**, from the causes and on the date stated above.

23A. SIGNATURE **John L. Wilson**  
John L. Wilson, Medical Director M. D.

23B. ADDRESS  
**US Marine Hospital, Balto, Md.**

23C. DATE SIGNED  
**10/16/50**

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS





525.50 8829

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8829

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Charles ALBERT HANSON

2. DATE  
OF  
DEATH

10/14/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

MARYLAND General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE #3112-02

D. STREET ADDRESS (If rural, give location)

Gilman Apts.-31st &amp; Calvert Sts.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

White

7. SINGLE, MARRIED

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

5-29-15

9. AGE (In years last birthday)

35

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

President

10B. KIND OF BUSINESS OR INDUSTRY

Lubricant

11. BIRTH PLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHARLES HANSEN

14. MOTHER'S MAIDEN NAME

CAROLYN WAGNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) (If yes, give war or dates of service)

Yes

World War I

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Ethel D. Hanson Gilman Apts.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Posterior Myocardial Infarct 2 day

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

Arteriosclerosis of Coronary Arteries

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/13/1950, to 10/14/1950, that I last saw the deceased alive on 10/14/1950, and that death occurred at 11:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Paul L. Herold

23B. ADDRESS

M. D.

Maryland General Hosp

23C. DATE SIGNED

10/15/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/18/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

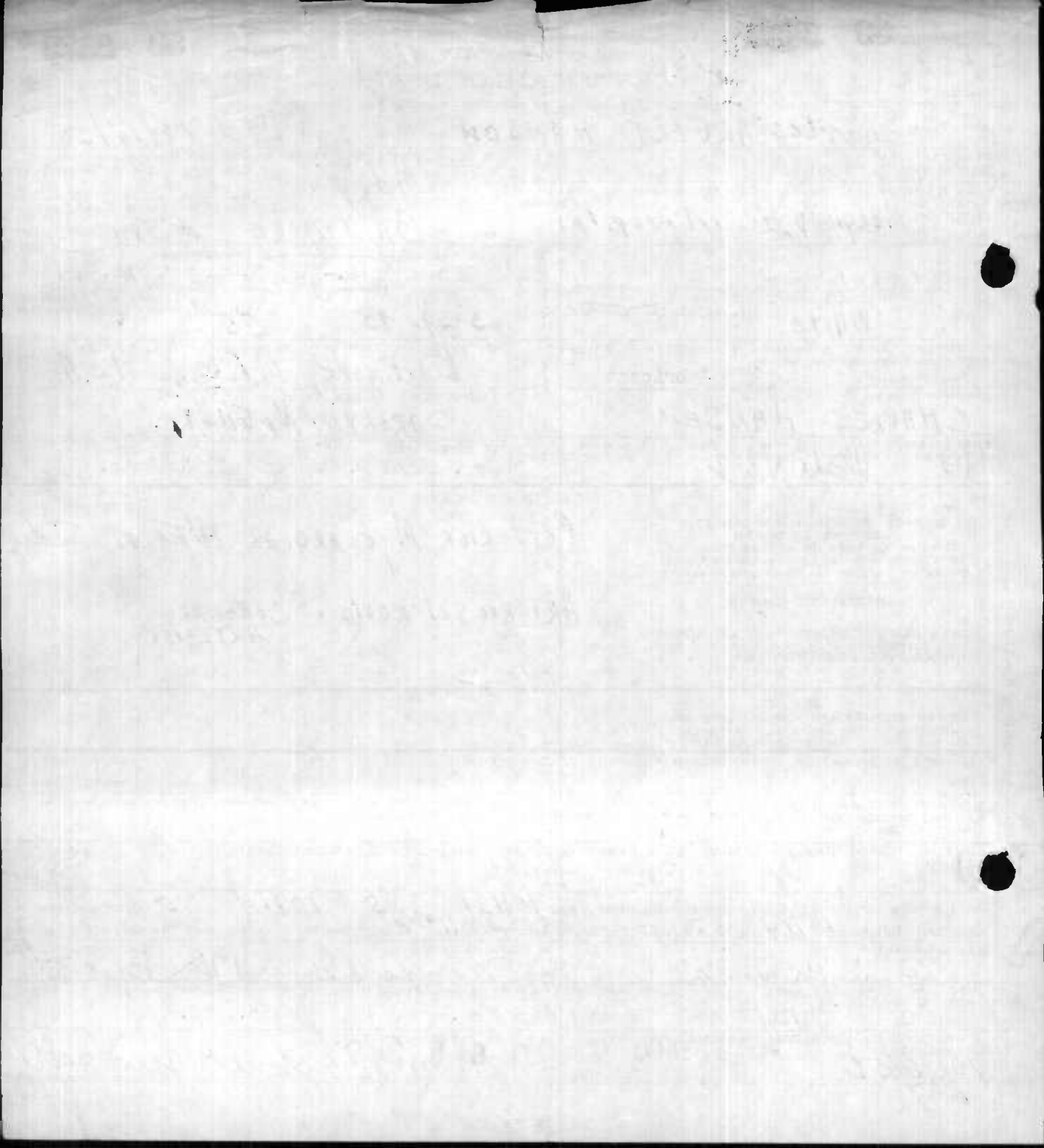
VS 150

29066

0942

MEDICAL CERTIFICATION

corrected by Baltimore City Health Department



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 8830**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) **PRUE TT = ESTHER V.**

2. DATE OF DEATH **Oct. 13, 1950**

3. PLACE OF DEATH:  
A. **Baltimore City, Maryland**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Md.** B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
**Sinai Hosp.**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore** **15-04**

c. Length of stay in Baltimore  
Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location)  
**2732 Pennsylvania Ave.**

5. SEX **female** 6. COLOR OR RACE **white** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **widowed**

8. DATE OF BIRTH **Jan. 10, 1869** 9. AGE (In years last birthday) **81** 10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **housewife** 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF **CERTIFICATION APPROVED BY**

13. FATHER'S NAME **J. K. Myers**

14. MOTHER'S MAIDEN NAME **E. J. LUBINSKI, M.D.**  
**unknown per: William [illegible] M.D.**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **no** (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.

17. INFORMANT **Mrs. Marion P. Mather** CHIEF OR ASSISTANT EXAMINER **2732 Pennsylvania**

18. **420.0** **E 902.0** CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) **Pulmonary Edema** (A) DUE TO **? 2 days**

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) **Myocardial Failure** DUE TO **? 4 days**  
(C) **Arteriosclerotic Heart Disease - year**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. **Fracture of Neck-rt femur** **- 17 days**

19A. DATE OF OPERATION **9-29-50** 19B. MAJOR FINDINGS OF OPERATION **Fracture, neck of right femur** 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) **home** 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **2732 Pennsylvania Ave, Zone 17**

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY **9-26-50, am.** 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? **fell out of chair to floor**

22. I hereby certify that I attended the deceased from **9-26** 19**50**, to **10-13**, 19**50**, that I last saw the deceased alive on **10-13**, 19**50**, and that death occurred at **10:45** p.m., from the causes and on the date stated above.

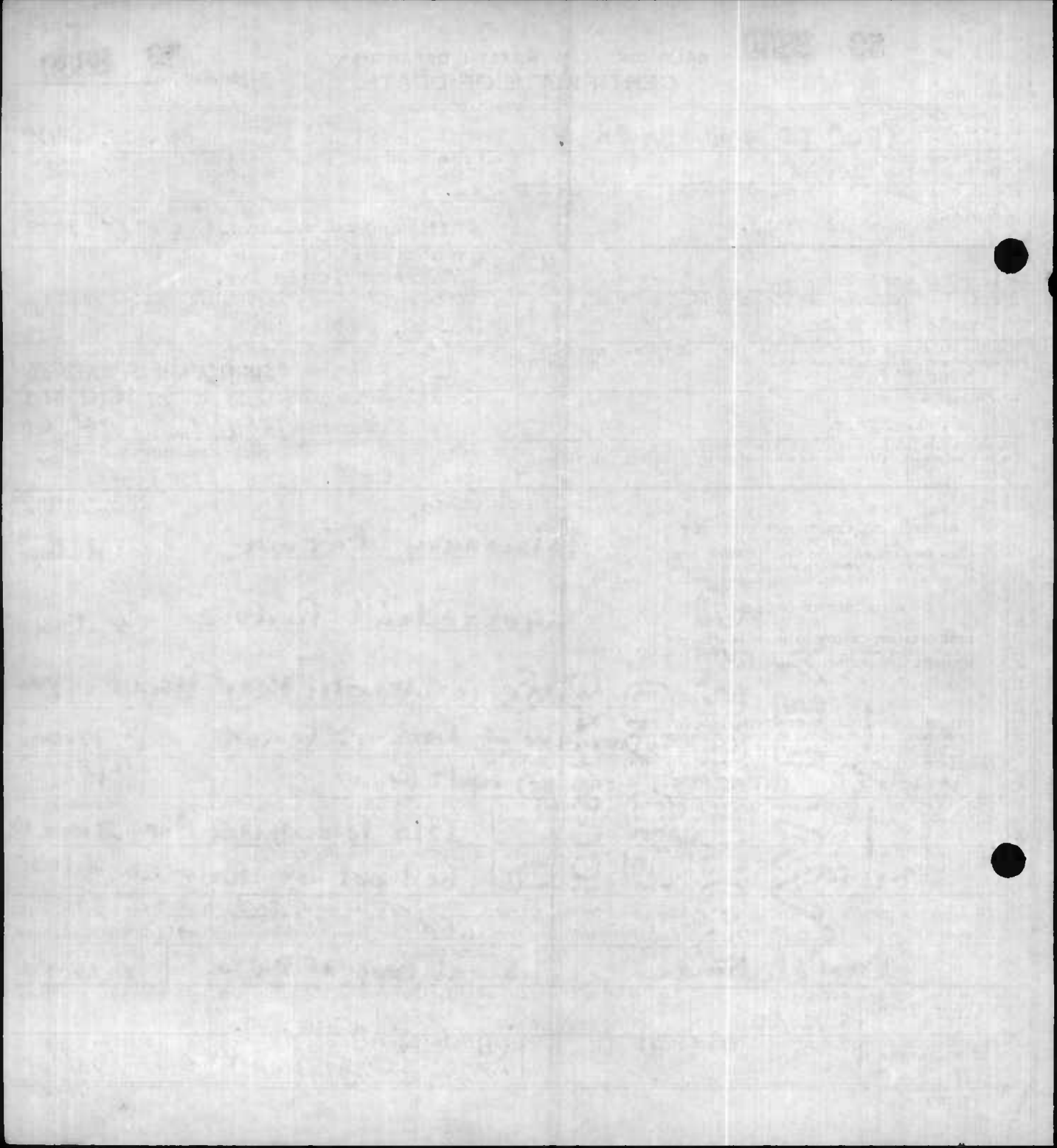
23A. SIGNATURE **[Signature]** M. D. 23B. ADDRESS **Sinai Hosp of Balto.** 23C. DATE SIGNED **10-14-50.**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **10/17/50** 24C. NAME OF CEMETERY OR CREMATORY **Ebenezer Cem.** 24D. LOCATION (City, town, or county) (State) **Chase, Md.**

DATE RECEIVED BY LOCAL REGISTRAR **OCT 16 1950** REGISTRAR'S SIGNATURE **[Signature]** 25. FUNERAL DIRECTOR **Wm. J. Pickens & Sons - Balto.** ADDRESS **186a**

VS 150 **N 820.0**

correct age is especially important. Physicians, please write the causes of death clearly and legibly.



530  
ES-131385

50 8831

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8831

Registered No.

BIRTH NO.

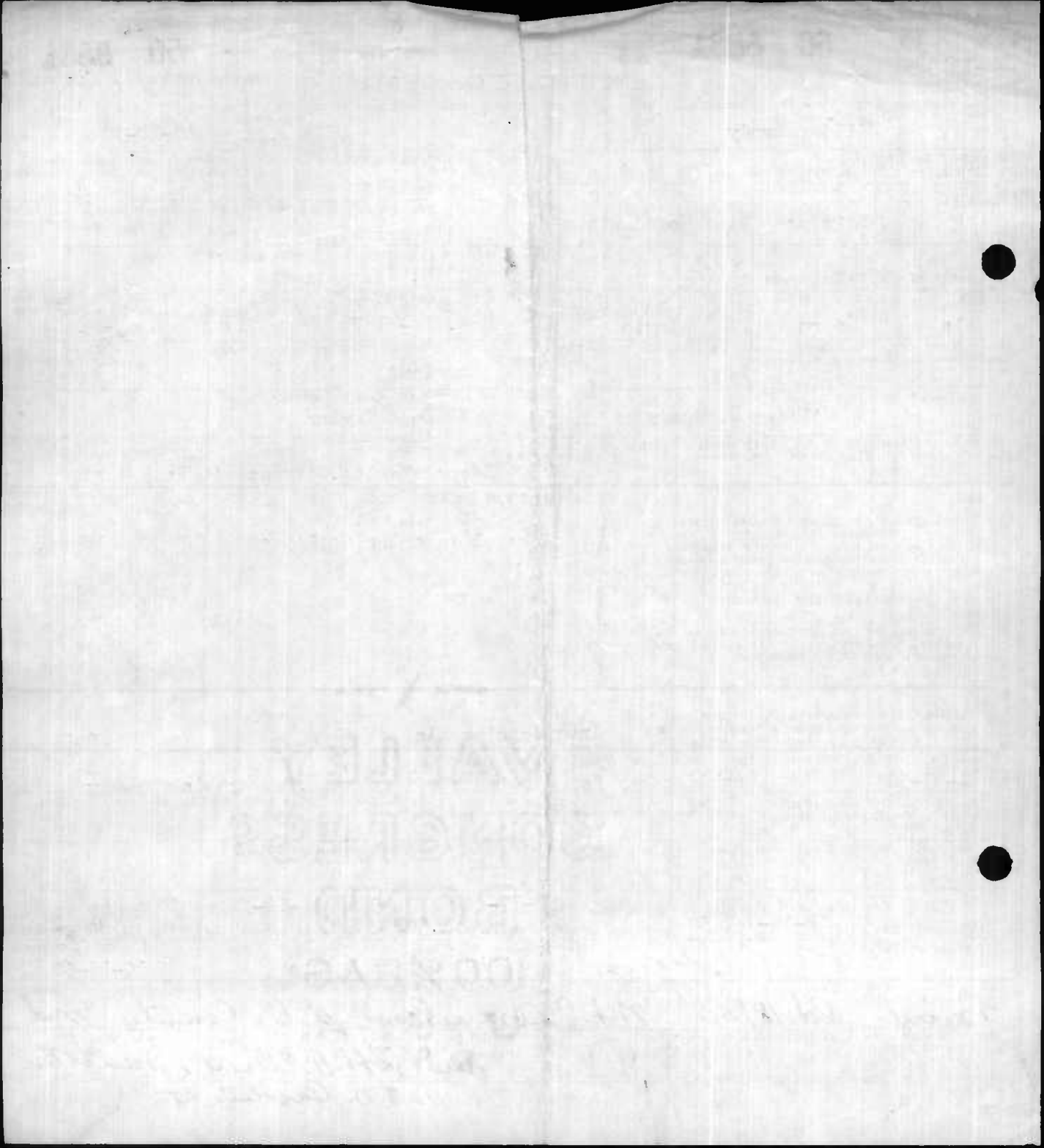
1. NAME OF DECEASED (Type or Print) William Bundy		2. DATE OF DEATH 10-14-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-62	
D. LENGTH OF STAY IN BALTIMORE Life Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 818 N. Eden Street	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 12- 1878
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 71
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William R. Bundy		14. MOTHER'S MAIDEN NAME Emma Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records*Balto. City Hospitals		ADDRESS 4940 Eastern Ave	

18. 177X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Peripheral Vascular Collapse DUE TO INTERVAL BETWEEN ONSET AND DEATH 12hrs.	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis years
---	--

19A. DATE OF OPERATION 1-23-50	19B. MAJOR FINDINGS OF OPERATION Orchidectomy for Carcinoma of Prostate, Inoperable	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 8-27-1949, to 10-14-1950, that I last saw the deceased alive on 10-14-1950 and that death occurred at 1.50P m., from the causes and on the date stated above.		
23A. SIGNATURE J. S. Rogers	23B. ADDRESS 4940 Eastern Avenue	23C. DATE SIGNED 10-15-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Oct. 18/50	24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem	24D. LOCATION (City, town, or county) (State) A. D. County Md
DATE RECEIVED BY LOCAL REGISTRAR OCT 16 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR Mrs. B. G. Elliott, Daughter	ADDRESS 1129 N. Caroline St

correct age is especially important. Physicians—please write the causes of death clearly and legibly.





P-3 203

8832

CERTIFICATE CORRECTED

10-19-50

50

8832

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN WILLIAM PADGETT

2. DATE  
OF  
DEATH

16 OCT 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street address or location)

Good Samaritan Hospital  
27 N. Carey St.Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE  
D. C.

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Washington

D. STREET ADDRESS (If rural, give location)

1000 C Street, N.E.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

Feb. 18, 1865

9. AGE (In years  
last birthday)

85

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Lillian Warfield, 1000 C St., N.E.  
Wash. D.C.

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Cerebral thrombosis  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Marked arteriosclerotic and  
hypertensive cardiovascular disease  
DUE TOOTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Previous left Hemiplegia

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 9 Oct, 1950, to 16 Oct, 1950, that I last saw the  
deceased alive on 15 Oct, 1950, and that death occurred at 6 A.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

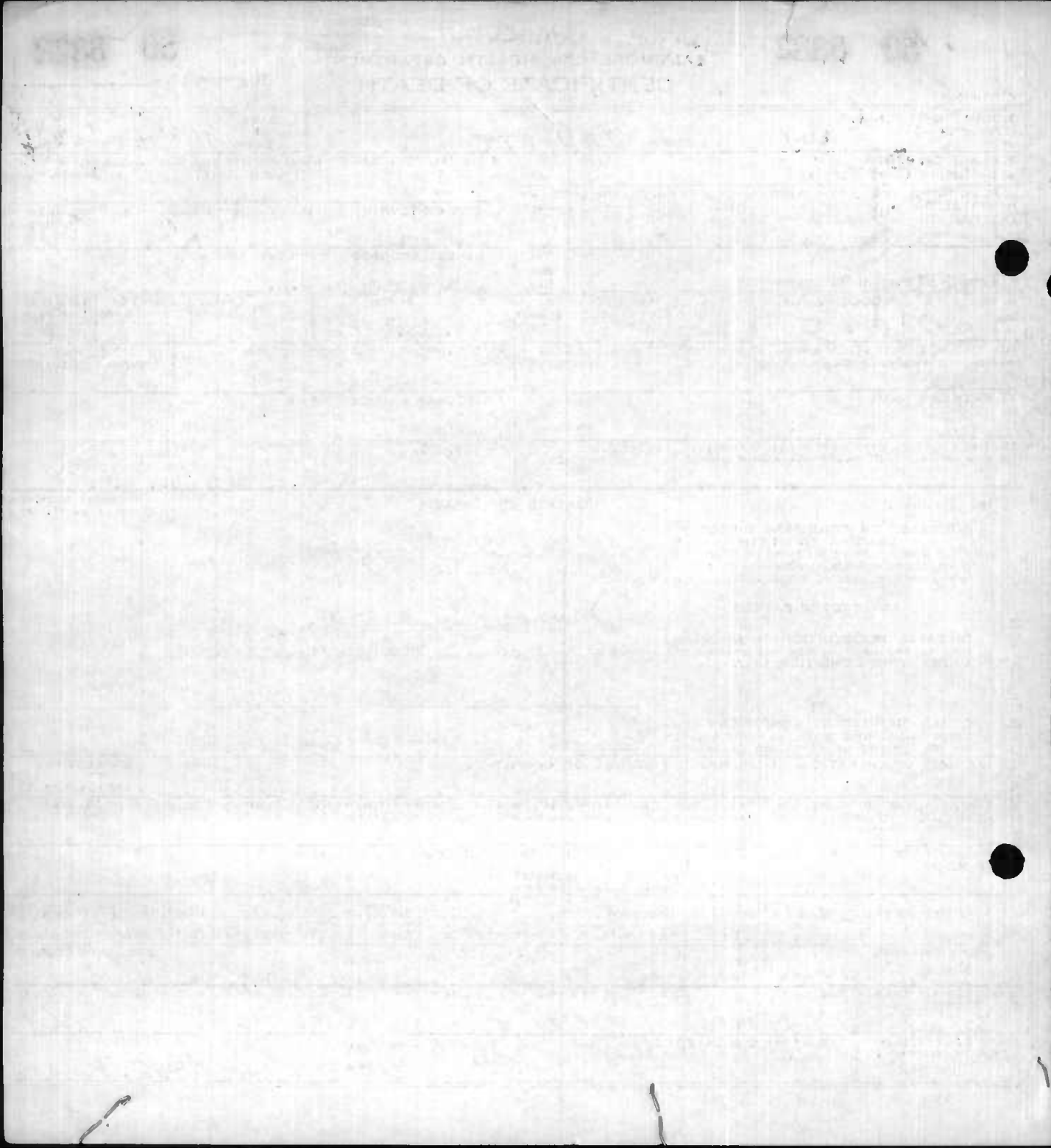
(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



H-300

50

8833

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50

8833

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARGARET E. HEATH

2. DATE  
OF  
DEATH

Oct 12, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Maryland General Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

27-01

D. STREET ADDRESS (If rural, give location)

2877 Chesterfield Ave.

c. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Feb. 27, 1893

9. AGE (in years)

57 yrs

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Jones

14. MOTHER'S MAIDEN NAME

Fredericka Koehler

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

Mrs. Ruth Whiteman

ADDRESS

Pelham Ave.

18. 420.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Arteriosclerotic heart disease with

DUE TO

(C) Coronary arteriosclerosis advanced

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from Oct 12, 1950, to Oct 12, 1950, that I last saw the deceased alive on Oct 12, 1950, and that death occurred at 5:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Paul B. Harold

M. D.

23B. ADDRESS

Maryland Gen. Hosp

23C. DATE SIGNED

Oct 13, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 16, 1950

24C. NAME OF CEMETERY OR CREMATOR

Mt. Olivet Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

HENRY SANDER & SONS, INC  
Baltimore Md.

ADDRESS

[Signature]

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J-520  
50 8834BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8834  
Registered No. 3698

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Annice R. James

2. DATE  
OF  
DEATH

Oct 13, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

1464 n. Carey st

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1464 n. Carey st

5. SEX

7

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

aug 15 1872

9. AGE (in years  
last birthday)

78

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Coates

14. MOTHER'S MAIDEN NAME

Georganna Stepmey

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Charles Ringgold 1464 n. Carey st

18. 592x

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebral

DUE TO

4 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

chr. nephritis

unknown

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

1D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-7-1949 to 10-13-1950 that I last saw the  
deceased alive on 10-13-1950. and that death occurred at 7:12 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

MEDICAL CERTIFICATION

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Letter in document file 50-8835- 11/6/50

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS  
1412 W. Lombard St  
Baltimore

18. 585X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from Oct 13, 1950, to Oct 14, 1950, that I last saw the deceased alive on Oct 13, 1950, and that death occurred at 00:15A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1900

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1899

ALBANY:

JOHN B. LEECH, PRINTERS

1900

1000 02

02 0000

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1900

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1899

ALBANY:

JOHN B. LEECH, PRINTERS

1900

1000 02

02 0000

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1900

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1899

ALBANY:

JOHN B. LEECH, PRINTERS

1900

1000 02

02 0000

STATE OF NEW YORK

IN SENATE

BIRTH NO. 50 8837		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		50 8837 Registered No.	
1. NAME OF DECEASED (Type or Print) <i>James O'Neill</i>			2. DATE OF DEATH <i>Oct 13, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>9-07</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>St. Joseph Hosp.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
D. STREET ADDRESS (If rural, give location) <i>1644- Montpelier St.</i>			E. LENGTH OF stay in Baltimore <i>life</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>7-1-1901</i>	9. AGE (In years last birthday) <i>49</i>	10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Adjuster</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>		
13. FATHER'S NAME <i>John M. O'Neill</i>			14. MOTHER'S MAIDEN NAME <i>Margaret Gibbons</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes 2</i>			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Miss Helen C. O'Neill</i>			ADDRESS <i>1644 Montpelier St.</i>		
18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary occlusion</i>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <i>Autopsy</i> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <i>natural causes</i> <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>William J. Belpre</i>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <i>10-13-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-17-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		25. FUNERAL DIRECTOR <i>John R. Moran</i>			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		ADDRESS <i>3000 E. Baltimore St.</i>	
<div style="display: flex; justify-content: space-between;"> <span>VS 151</span> <span>45073</span> <span>094a</span> </div>					

Correct age is especially important. If uncertain, please write the range in death history and notify.

MEDICAL CERTIFICATION

Miss Margaret Holdorf

20 2341

CHURCHVILLE OH OHIO

RECEIVED BY THE CHURCH OF CHRIST

18 1871



ed No. 8826

10-15-50

before admission)

(If outside corporate limits, write RURAL and give township)

II Under 1 Year	II Under 24 Hours
Months: Days	Hours: Min.

12. CITIZEN OF  
WHAT COUNTRY?  
USA

ADDRESS

Robert H. Boyse Son

INTERVAL BETWEEN  
ONSET AND DEATH

(C)

*Asferoscientific C.V. Dis.*

2 + 925

YES ☐ NO ☒

21F. HOW DID INJURY OCCUR?

23c. DATE SIGNED  
10-15-50

Baltimore

ADDRESS

Lilly & Zeiler, 403 S. Wolfe Street

0934

RECEIVED  
STATE OF NEW YORK

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RECEIVED

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T-520 8839

50 8839

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)			2. DATE OF DEATH		
ANNA M. THOMAS			10-14-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland 841 S. Conkling St.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
B. FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE Md.		
C. Length of stay in Baltimore			B. COUNTY		
Life			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
Yrs. Mos. Days			Baltimore 26-09		
5. SEX			D. STREET ADDRESS (If rural, give location)		
Female			841 S. Conkling St.		
6. COLOR OR RACE			E. DATE OF BIRTH		
White			March 18, 1874		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)			9. AGE (In years last birthday)		
Widowed			76		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Retired			Baltimore, Md.		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
House Work			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Anthony Suchanek			Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16. SOCIAL SECURITY NO.		
No			None		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)			17. INFORMANT ADDRESS		
No			Mrs. Lee Mack 841 S. Conkling St.		

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Arteriosclerotic Cardiovascular Disease*

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Generalized Arteriosclerosis*

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) *Hypertension*  
*Diabetes Mellitus (mild)*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-13-1944 to 10-12-1950, that I last saw the deceased alive on 10-12-1950, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

23A. SIGNATURE

*John Constantine*

M. D.

23B. ADDRESS

233 S. Conkling St.

23C. DATE SIGNED

10-14-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 17, 1950

24C. NAME OF CEMETERY OR CREMATORY

Sacred Heart Cemetery

24D. LOCATION (City, town, or county)

(State)

4701 German Hill Rd. Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 16 1950

*John Constantine**Charles S. Feiler*

901 S. Conkling St.

0523

03

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03

DEPARTMENT OF THE ARMY  
OFFICE OF THE ADJUTANT GENERAL

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ES-142525

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8840

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Anna Gaphardt

2. DATE  
OF  
DEATH

10-15-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

510 Madeira Street (5)

c. Length of stay in Baltimore

Life

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

July 13, 1879

9. AGE (in years  
last birthday)

71

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR  
INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Frank -----

14. MOTHER'S MAIDEN NAME

Sophia?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

none

none

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS 4940

Records\* Balto. City Hospitals Eastern Av

18. 584X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Cardiac Failure

DUE TO

Unknown

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Acute Cholecystitis  
Cirrhosis of the liver

DUE TO

4 Days  
Unknown

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.19A. DATE OF OPERATION  
10-14-50

19B. MAJOR FINDINGS OF OPERATION

Acute Cholecystitis with Cholelithiasis

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 10-14, 1950, to 10-15, 1950, that I last saw the  
deceased alive on 10-15, 1950, and that death occurred at 2:50 A. from the causes and on the date stated above.

23A. SIGNATURE

P. S. Rogers M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

10-15-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 18, 1950

24C. NAME OF CEMETERY OR CREMATORY

Balto Cem.

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. LINEAL DIRECTOR

ADDRESS

OCT 16 1950

1950 10 16 9 50 00

Philip's Henry's Sons

3224  
Cecil Ave. H

0393 00

0102 02

22151400

11105

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11105



N.D. \* 138323

## BALTIMORE CITY HEALTH DEPARTMENT

50 8841

BIRTH NO. 50 8841 18-19136

## CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED  
(Type or Print)

Beverly Ann Christopher

2. DATE  
OF  
DEATH

October 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospital

4940 Eastern Ave.

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2230 E. Jefferson St.

C. Length of stay in Baltimore

Life

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Sept. 5, 1948

9. AGE (in years  
last birthday)

2

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Leonard Christopher

14. MOTHER'S MAIDEN NAME

Anna Samek

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT Baltimore City Hospitals  
Records: 4940 Eastern Ave.

18. 010X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Tuberculous Meningitis

DUE TO

5 mos.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-24 1950, to 10-15 1950, that I last saw the  
deceased alive on 10-15 1950, and that death occurred at 12:45 P. M., from the causes and on the date stated above.

23A. SIGNATURE

J. S. Rogers M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

10-16-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

10-17-50

24C. NAME OF CEMETERY OR CREMATORY

HOLY REDEEMER

24D. LOCATION (City, town, or county)

BALTIMORE

(State)

MD

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FRANK EVACH &amp; SON 900 N. CHESTER ST

OCT 16 1950

014.0

1968 02

1968 02

H-140  
50 8842BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8842

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>HAFELE, Bessie May</b>			2. DATE OF DEATH <b>Oct. 15, 1950.</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Hospital for the Women of Md.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 21-02</b>		
Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>1291 Cleveland St., -30-</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>M</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>April 11, 1887</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fitter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Barline Bros.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington Co., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Samuel Chaney</b>		14. MOTHER'S MAIDEN NAME <b>Helen Elizabeth Jones.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-78-6243</b>		17. INFORMANT <b>John Hafele</b> ADDRESS <b>Son 39 N. ...</b>	

18. <b>154X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <b>Metastatic Carcinoma of rectum.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO _____		_____	
(C) _____		_____		_____	

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <b>1943.</b>		19B. MAJOR FINDINGS OF OPERATION <b>Colostomy for carcinoma of rectum</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <input type="checkbox"/>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	

22. I hereby certify that I attended the deceased from **Oct. 2, 1950**, to **Oct. 15, 1950**, that I last saw the deceased alive on **Oct. 14, 1950**, and that death occurred at **2:25** m., from the causes and on the date stated above.

23A. SIGNATURE <b>R. C. Warkley</b>		23B. ADDRESS <b>Women's Hospital</b>		23C. DATE SIGNED <b>10-15-50.</b>	
--	--	---	--	--------------------------------------	--

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 18/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>London Pl., 3801 Frederick Rd. Balt.</b>		24D. LOCATION (City, town, or county) (State) <b>Md.</b>	
--	--	--------------------------------	--	---	--	---	--

DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 16 1950</b>		REGISTRAR'S SIGNATURE <b>John H. ...</b>		25. FUNERAL DIRECTOR <b>Henry W. ...</b>		ADDRESS <b>4101 Edmondson Ave.</b>	
--	--	---	--	---	--	---------------------------------------	--

VS 150

6904Q

046d

100 50

100 50

*[Faint, illegible handwriting on lined paper]*

K-400

50 8843

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8843  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EMIL K. H. KEHL

2. DATE  
OF  
DEATH

OCT 14 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

B. COUNTY

before admission)

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1928 ORLEANS ST

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

6-04

D. STREET ADDRESS (If rural, give location)

1928 ORLEANS ST.

c. Length of stay in Baltimore

36 YRS

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

JULY 23 1895

9. AGE (in years  
last birthday)

55

10 Under 1 Year  
Months; Days11 Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

FOREMAN

10B. KIND OF BUSINESS OR  
INDUSTRY

CNEP. LIGHTING &amp; TOWING CO.

11. BIRTHPLACE (State or foreign country)

GERMANY

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

? KEHL

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

-

16. SOCIAL  
SECURITY NO.

215-07-0009

17. INFORMANT

ADDRESS

HENRY KEHL 1928 ORLEANS ST.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Myocardial Degeneration 3 ms.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Arteriosclerosis - Indefinite

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Portal Cirrhosis - 12 ms?

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

none

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from June 12, 1950, to Oct 14, 1950, that I last saw the  
deceased alive on 10/14, 1950, and that death occurred at 10:45 p.m., from the causes and on the date stated above.

SIGNATURE

M. Miller

M. D.

23B. ADDRESS

1613 E Baltimore ST

23C. DATE SIGNED

10/16/50

24A. CREMA-  
TORIAL (Specify)

24B. DATE

OCT 18 1950

24C. NAME OF CEMETERY OR CREMATORY

HOLY REDEEMER CEM

24D. LOCATION (City, town, or county)

4430 BELAIR RD

(State)

MD.

RECEIVED BY

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

61950

M. Williams, M.D.

Dippel Bros. 1800 E Lombard St

52352

124.6

MEDICAL CERTIFICATION

24A.	24A.
DATE REC'D	DATE REC'D
LOCAL REC'D	LOCAL REC'D
OCT 1	OCT 1
VS 150	VS 150



4-550

50 8844

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8844

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE FRANCIS LEMON

2. DATE  
OF  
DEATH

10/14/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)

A. STATE MARYLAND B. COUNTY BALTIMORE

5. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

UNION MEMORIAL HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

UPPERCO

6. Length of stay in Baltimore

5 Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

STAR HILL FARM 5300

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

NOV 1 1876

9. AGE (In years)

74 3/4

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

COLONEL

10B. KIND OF BUSINESS OR  
INDUSTRY

ARMY

11. BIRTHPLACE (State or foreign country)

CHICAGO, ILLINOIS

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN LEMON

14. MOTHER'S MAIDEN NAME

DORA LEMOINE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES W.W.-#1

16. SOCIAL  
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

18. 331X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

cerebral hemorrhage

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 10/9 1950, to 10/14, 1950, that I last saw the  
deceased alive on 10/14, 1950, and that death occurred at 9:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Alfred S. Nelson

M. D.

23B. ADDRESS

Union Memorial Hospital  
Baltimore 18, Md.

23C. DATE SIGNED

10/14/50

24A. BURIAL, CREM-  
ATION, REMOVAL (Specify)

24B. DATE

Oct 17/50

24C. NAME OF CEMETERY OR CREMATORY

Greenmount Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 16 1950

VS 150

Stewart & Mowin Co., 108 W. North Ave  
Baltimore, Md.

Stewart &amp; Mowin Co., 108 W. North Ave

City #1. 083a

290 91

MEDICAL CERTIFICATION

*Copy*

1128 08

*[Faint, illegible text throughout the page, possibly bleed-through from the reverse side.]*

T-600  
50 8845BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8845

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Adele Dohme True

2. DATE  
OF  
DEATH

October-15-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 28 Charlotte Place

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

at home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE Maryland B. COUNTY Baltimore City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-11

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

28 Charlotte Place

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Apr-3-1871

9. AGE (In years  
last birthday)

79 years

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Charles E. Dohme

14. MOTHER'S MAIDEN NAME

Ida Schulz

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Dr. A. R. L. Dohme (Brother) Baltimore, Md.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) ...  
DUE TO

Coronary Thrombosis

Immediate

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) ...  
DUE TO

Generalized arteriosclerosis &amp; coronary

Indefinite

(C) ...

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from , 19 / to Oct 10, 1950 that I last saw the  
deceased alive on Oct 10, 1950 and that death occurred at 7:47 AM, from the causes and on the date stated above.

23A. SIGNATURE

Isaac M Beck M. D.

23B. ADDRESS

100 E. 23rd St Baltimore, Md

23C. DATE SIGNED

Oct 16-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Oct-18-1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town, or county)

Auburn, Maine

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

500

25. FUNERAL DIRECTOR

ADDRESS

Stewart &amp; Mowen Co., 108 W. North Ave.

City #1. 094a

OCT 16 1950

VS 150

Huntington Williams, M.D.

3000

00

3000

00

RECEIVED



M-240 8846

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8846  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Caleb Cabell Bernard Michael

2. DATE  
OF  
DEATH

Oct 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

University Hospital (DOA)

Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 6-1876

9. AGE (In years  
last birthday)

74

11 Under 1 Year  
Months Days12 Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR  
INDUSTRY

Contractor

11. BIRTHPLACE (State or foreign country)

Annapolis Co Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Michael

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Charlotte E Michael Mt Gomery Rd

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Coronary Disease

## ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Kanner, Jr.

M.D.

23B. CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒

23C. DATE SIGNED

Oct. 15, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

10-18-50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cmn, Frederick Rd

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 16 1950

Edward Toulson 2359 Wash Blvd

NO 2040

NO 2040



R-1603 8847

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8847  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Louis Joseph Ruppert

2. DATE  
OF  
DEATH Oct. 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

none

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1818 Linden Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

14-01

D. STREET ADDRESS (If rural, give location)

1818 Linden Ave.

C. Length of stay in Baltimore

life Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

April 6, 1894

9. AGE (In years last birthday)

56

If Under 1 Year

If Under 24 Hours

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Glass Blower

10B. KIND OF BUSINESS OR INDUSTRY

proprietor

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Joseph Ruppert

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Louis F. Ruppert - 1818 Linden Ave.

18. 002 X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Broncho pneumonia

1 wk

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

Bilateral Pulmonary Tuberculosis with cavitation

years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 24 Sept, 1950, to 13 Oct, 1950, that I last saw the deceased alive on 30 Oct, 1950, and that death occurred at 11:05 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

burial

10/17/50

Meadowridge Mem. Cemetery

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

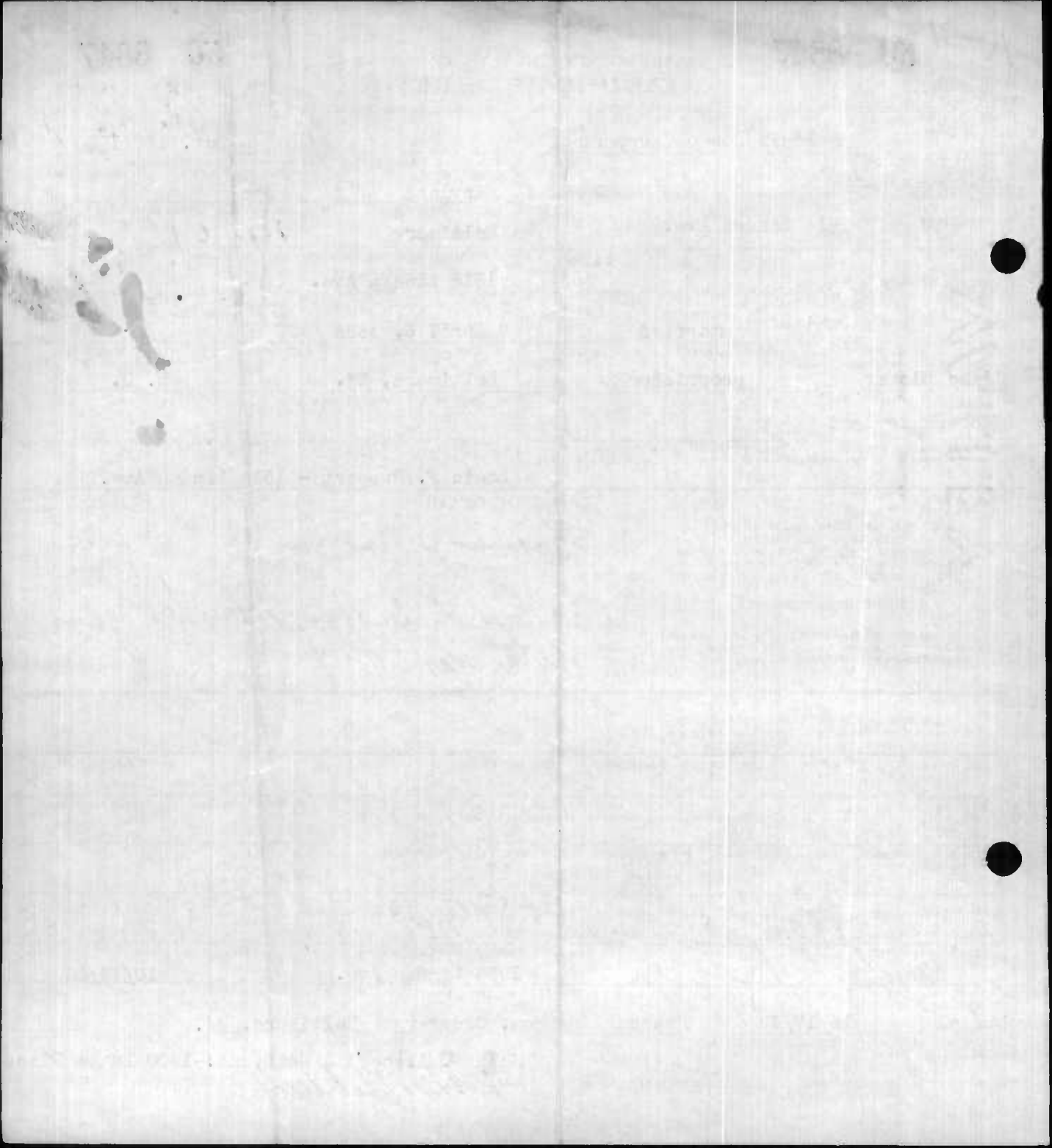
25. FUNERAL DIRECTOR

ADDRESS

John O. Mitchell &amp; Sons, Inc. - 1900 Eutaw Place

Dr. Ruppert 29035

0136



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 8848  
Registered No.

BIRTH NO. 50 8848

1. NAME OF DECEASED (Type or Print) <b>CATHERINE DISHROON</b>		2. DATE OF DEATH <b>Oct. 12, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 3-02</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>1144 E. Lombard St.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>3/15/20</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	9. AGE (In years last birthday) <b>30</b>
13. FATHER'S NAME <b>Mr. Known</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>None</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Cleveland Robinson</b>	
		ADDRESS <b>1144 E Lombard</b>	

18. **002X**

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Pulmonary tuberculosis**

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Inspection & Inq.** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED  
**Oct. 13, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**OCT 16 1950**

VS 151

7208A

0134

MEDICAL CERTIFICATION

Correct age is especially important. If stated, please write the cause of death clearly and briefly.

50 - 8818

PAID HERE FOR DEATH BENEFIT  
DEATH OF DEATH

50 8818

F-320

ES-142451 50

8849

BALTIMORE CITY HEALTH DEPARTMENT

50 8849

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

Maria N. Fettweis,

## 2. DATE

OF

DEATH

10-14-50

## 3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

Baltimore City Hospitals

Yrs.

Mos.

Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

26-01

D. STREET ADDRESS (If rural, give location)

5517 Summerfield Avenue (6)

## 5. SEX

Female

## 6. COLOR OR RACE

White

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

## 8. DATE OF BIRTH

Dec. 17, 1881

## 9. AGE (In years last birthday)

68

## 10. Under 1 Year

Months: Days

## 11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

AT Home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

? Winterhager

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS 4940

Records\* Balto. City Hospitals Eastern Ave

18. 470.0

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

3 Days

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Anoxia

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Heart Disease  
Diabetes MellitusUnknown  
Unknown

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-11, 1950 to 10-14, 1950, that I last saw the deceased alive on 10-14, 1950, and that death occurred at 5:00 p. m. from the causes and on the date stated above.

23A. SIGNATURE

J. S. Rogers

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

10-15-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-17-50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county)

Balto Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

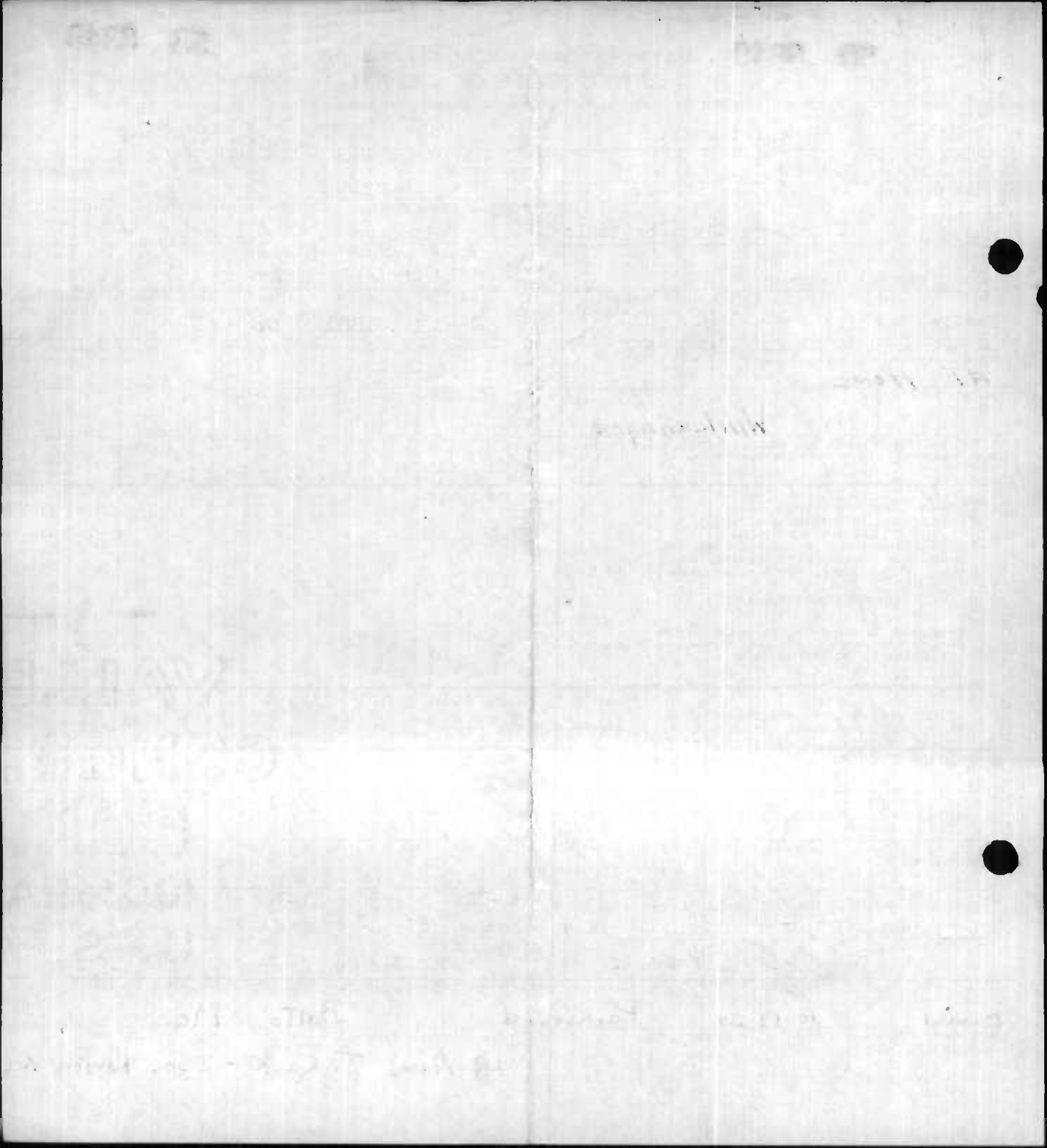
1250000 Leonard J. Ruck - 5305 Harford Rd.

VS 150

Kuntigton Williams, M.D.

061

correct age is especially important. Physicians: please write the causes of death clearly and legibly.





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

WARREN WALLACE BENNER

2. DATE  
OF  
DEATH

Oct. 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

US Marine Hospital

Wyman Pk. Drive & 31st St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Delaware

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Bowers

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

86 days

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Wid.

8. DATE OF BIRTH

7/18/86

9. AGE (In years last birthday)

64

If Under 1 Year Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

deck hand

10B. KIND OF BUSINESS OR INDUSTRY

Seafarer

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Herman Benner

14. MOTHER'S MAIDEN NAME

Fietta Richards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

?

16. SOCIAL SECURITY NO.  
221-03-9872

17. INFORMANT ADDRESS  
Records- US Marine Hospital, Balto, Md.

18. 592X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic glomerulonephritis with uremia.  
DUE TO ( Blood urea nitrogen equals 152)

Several yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 22, 1950, to Oct. 16, 1950, that I last saw the deceased alive on Oct. 16, 1950 and that death occurred at 1 A. m., from the causes and on the date stated above.

23A. SIGNATURE  
John L. Wilson, Medical Director

M. D.

23B. ADDRESS  
US Marine Hospital, Balto, Md.

23C. DATE SIGNED  
10/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

10/16/50

24C. NAME OF CEMETERY OR CREMATORY

Warlington Cem.

24D. LOCATION (City, town, or county)

Philadelphia, Pa.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 16 1950  
VS 150

673 55

131 2 md.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

REBECCA JONAS

2. DATE  
OF  
DEATH

October 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE Maryland

B. COUNTY

before admission)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Sinai Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Pikesville

D. STREET ADDRESS (If rural, give location)

4218 Lowell Drive

c. Length of stay in Baltimore

55 yrs.

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

1867

9. AGE (In years last birthday)

10 Under 1 Year Months Days

11 Under 24 Hours Hours Min.

85

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Lithuania

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

Nathan Friedlander

14. MOTHER'S MAIDEN NAME

Minnie ??

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Samuel Jonas- 4218 Lowell Ave. Pikesville, Maryland

18. E900.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Cerebral Decomposition

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Temporary Ischemic & Bilateral Subdural Hematomas

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY

R. J. Fisher

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

for: C. J. Lubinski, M.D.

CHIEF OR ASST. MEDICAL EXAMINER.

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

Accident

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

4218 Lowell Drive, Pikesville, Md.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

October 15, 1950 2 P. m.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell down cellar steps (inside)

22. I hereby certify that I attended the deceased from 10-15, 1950, to 10-15, 1950, that I last saw the deceased alive on 10-15, 1950, and that death occurred at 9:35 p. m., from the causes and on the date stated above.

23A. SIGNATURE

William Pangue

M. D.

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

10-14

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-17-50

24C. NAME OF CEMETERY OR CREMATORY

Ethamedrosh Hagodol

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY LOCAL REGISTRAR

OCT 17 1950

REGISTRAR'S SIGNATURE

William Pangue

25. FUNERAL DIRECTOR

ADDRESS

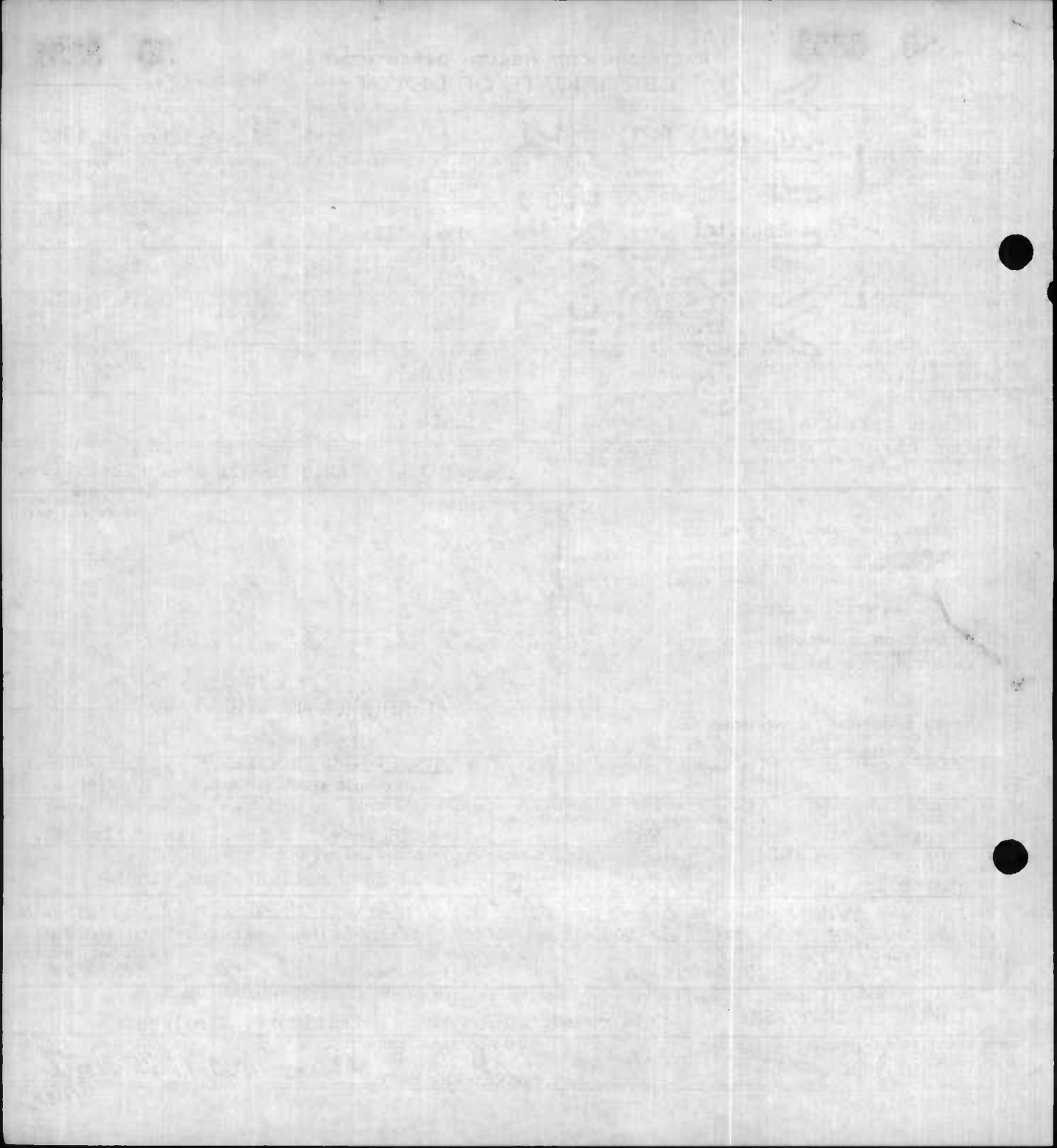
S. L. Ginn & Bros. 1124-26 W. North Ave

VS 150

N 801.2

186a

Ave



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Mamie L. Quinn</i>		2. DATE OF DEATH <i>Oct. 13, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1305 Winchester St.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>1305 Winchester St.</i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1305 Winchester St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore, M.D. 16-02</i>	
c. Length of stay in Baltimore <i>Life time</i>		D. STREET ADDRESS (If rural, give location) <i>1305 Winchester St.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Aug. 14, 1869</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, M.D.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Daniel Patterson</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Jones</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Eva E. Queen</i>		ADDRESS <i>1305 Winchester St.</i>	

18. <i>443X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Hypertensive Cardiovascular Disease</i> DUE TO (B) <i>Arteriosclerosis</i> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH
---	--	----------------------------------

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *May 11*, 1950 to *Oct. 13*, 1950, that I last saw the deceased alive on *Oct. 2*, 1950, and that death occurred at *7 P. m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>R. Jackson M.D.</i>	23B. ADDRESS <i>600 N. Arlington Ave.</i>	23C. DATE SIGNED <i>10-15-50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Oct. 17</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cemetery</i>
24D. LOCATION (City, town, or county) (State) <i>D. Co. County</i>	25. FUNERAL DIRECTOR'S ADDRESS <i>Lattie Gross 1408 Oakland Ave</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>Oct 17 1950</i>		
REGISTRAR'S SIGNATURE <i>[Signature]</i>		

10-22-52

10-22-52

CERTIFICATE OF DEATH

10-22-52

10-22-52

10-22-52

10-22-52



100 50 8853

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8853  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

PASQUALE ZOPPO Zoppo

2. DATE  
OF  
DEATH

October 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Mercy Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

5-02

D. STREET ADDRESS (If rural, give location)

506 Ensor Street

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

NOT KNOWN

9. AGE (In years  
last birthday)

About 60 yrs

H Under 1 Year  
Months: DaysH Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

Cement Finisher Self employed

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Pasquale Zoppo

14. MOTHER'S MAIDEN NAME

Carmelena P

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Mary Krause 1305 Clifton Ave

18. E812.4

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Crushed chest

DUE TO Ruptured diaphragm, right

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Ruptured liver

DUE TO Right hemothorax

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

W. Lexington and Gay Street

4/1

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

October 15, 1950 1.45pm.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22. I certify that I took charge of the remains described above, held an autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. [Signature]

23B. CHIEF MEDICAL EXAMINER.....

23C. DATE SIGNED

ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

Oct. 16, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

10-19-1950

Holy Redeemer Cemetery Baltimore

Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 17 1950

[Signature]

Elmer W. Conklin 924 E. Eager St.

VS 151

N 862.2

57124

170-C ✓

correct age is especially important. Informants: please state the cause of death clearly and briefly.

MEDICAL CERTIFICATION

NO. 10

DEPARTMENT OF HEALTH

NO. 10

CERTIFICATE OF DEATH

DATE OF DEATH

426 50 8854

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8854

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

PAULINE CAROLINE VOELKER

2. DATE  
OF  
DEATH

Oct. 14. 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE 3215 Elmora Ave.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 8-01D. STREET ADDRESS (If rural, give location)  
3215 Elmora Ave.

c. Length of stay in Baltimore

65 yrs

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

July. 24. 1878

9. AGE (in years  
last birthday)

72 yrs

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Drawerr

14. MOTHER'S MAIDEN NAME

Catherine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Mrs. Catherine Westerham  
3215 Elmora Ave. - 1318. 174X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

Carcinoma of Uterus

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

1946-

2 day

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Chronic Interstitial Nephritis

3 year

19A. DATE OF OPERATION

6-18-1946

19B. MAJOR FINDINGS OF OPERATION

Carcinoma in scraping from uterus

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

None

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

None

22. I hereby certify that I attended the deceased from 6-18-1946, 19 to 10/14, 1950, that I last saw the  
deceased alive on 19, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. David Miller

23B. ADDRESS

4510 Harford Rd

23C. DATE SIGNED

10/15/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 17. 1950

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

HENRY SANDER &amp; SONS, INC.

ADDRESS

Baltimore Md. [Signature]

MEDICAL CERTIFICATION

Government of Victoria  
Hepburn's Shafford  
1946-2 days

2-18-1946  
Government in working form when  
shown illustrative progress  
3 days

to home office  
4210 Shafford Rd  
10/12/20  
10/12/20  
10/12/20  
10/12/20

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 1

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Frank Watson</i>			2. DATE OF DEATH <i>10/14/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Provident Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>16-03</i>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <i>813 N Mount St</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>Colonia</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>March 3 1916</i>		9. AGE (In years last birthday) <i>34</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stone LABORER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Stone CONST.</i>	11. BIRTHPLACE (State or foreign country) <i>Dunking Co Va</i>		12. CITIZEN OF WHAT COUNTRY? _____
13. FATHER'S NAME <i>Richard Watson -</i>			14. MOTHER'S MAIDEN NAME <i>Mary Ellen Bell</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>226-16-3750</i>	17. INFORMANT ADDRESS <i>Marie Lee 1752 Llewellyn Ave</i>		

18. *003.0*

**CAUSE OF DEATH**

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) \_\_\_\_\_  
DUE TO

*Pleurisy (left side)  
Possible Tuberculosis*

INTERVAL BETWEEN ONSET AND DEATH

*9-10-50*

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_  
DUE TO

*Possible Pericardial Effusion*

*10-14-50*

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *0*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *10/10/50*, 19*50*, to *10/16/50*, 19*50*, that I last saw the deceased alive on *10/16/50*, 19*50*, and that death occurred at *4:30 am.*, from the causes and on the date stated above.

23A. SIGNATURE

*Aristomene Nicolas*

M. D.

23B. ADDRESS

*Provident Hospital*

23C. DATE SIGNED

*10/16/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

*Oct 18 1950*

24C. NAME OF CEMETERY OR CREMATORY

*Mt. Calvary Cem*

24D. LOCATION (City, town, or county)

*A. G. County Md*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Therese J. Elliott*

25. FUNERAL DIRECTOR

*Therese J. Elliott & Daughter*

ADDRESS

STATE OF NEW YORK  
DEPARTMENT OF TAXATION

IN SENATE	
JANUARY 1, 1900	
REPORT OF THE	
COMMISSIONER OF TAXATION	
FOR THE YEAR 1899	
ALBANY:	
J. B. LIPPINCOTT & CO. PRINTERS	
1900	



50 8856

50 8856

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JIA JENNIE HETTEMAN

2. DATE  
OF  
DEATH

10-16-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md

B. COUNTY

15-02

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

1709 No Monroe St Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1709 No Monroe St

C. Length of stay in Baltimore

58

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

9. AGE (in years  
last birthday)

68

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Kansas

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Not known

14. MOTHER'S MAIDEN NAME

Sarah

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Louis Kettelman - Jane

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Lobes Pneumonia

DUE TO Coronary Thrombosis

(B) Arteriosclerosis

DUE TO Mitral Insufficiency

(C) Hypertension

3 days

3 yrs

6 yrs

124 yrs

12 yrs +

12 " ?

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-18-38 to 10-16-1950, that I last saw the deceased alive on Oct. 16, 1950, and that death occurred at 6:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Harry Linden

M. D.

23B. ADDRESS

14 S. Broadway

23C. DATE SIGNED

Oct. 16, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

10-17-50

24C. NAME OF CEMETERY OR CREMATORY

Rosedale

24D. LOCATION (City, town, or county)

Baltimore, Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

[Signature] 2100 Eutaw Pl

ADDRESS

VS 150

0926

under  
74 to 700

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print) **IDA BRENNER**

2. DATE OF DEATH **10-15-58**

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Md** B. COUNTY \_\_\_\_\_

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
**SINAI HOSP.**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore 13-04**

c. Length of stay in Baltimore **62** Yrs. **None** Days

D. STREET ADDRESS (If rural, give location)  
**2214 Whittier Ave**

5. SEX **Female** 6. COLOR OR RACE **White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**Widowed**

8. DATE OF BIRTH \_\_\_\_\_

9. AGE (In years last birthday) **82** Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)  
**Housewife**

10B. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_

11. BIRTH PLACE (State or foreign country)  
**Russia**

12. CITIZEN OF WHAT COUNTRY? \_\_\_\_\_

13. FATHER'S NAME  
**Abraham**

14. MOTHER'S MAIDEN NAME  
**Hannah**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. \_\_\_\_\_

17. INFORMANT ADDRESS  
**Abraham Brenner - Same**

18. **420.0** I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

**CVA**

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

DUE TO

(C)

**Hypert. A. B. H. D.**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **0**

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **10-14**, 19**58**, to **10-15**, 19**58**, that I last saw the deceased alive on **10-15**, 19**58**, and that death occurred at **4:30 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**0611/1958**

**William Burgess**

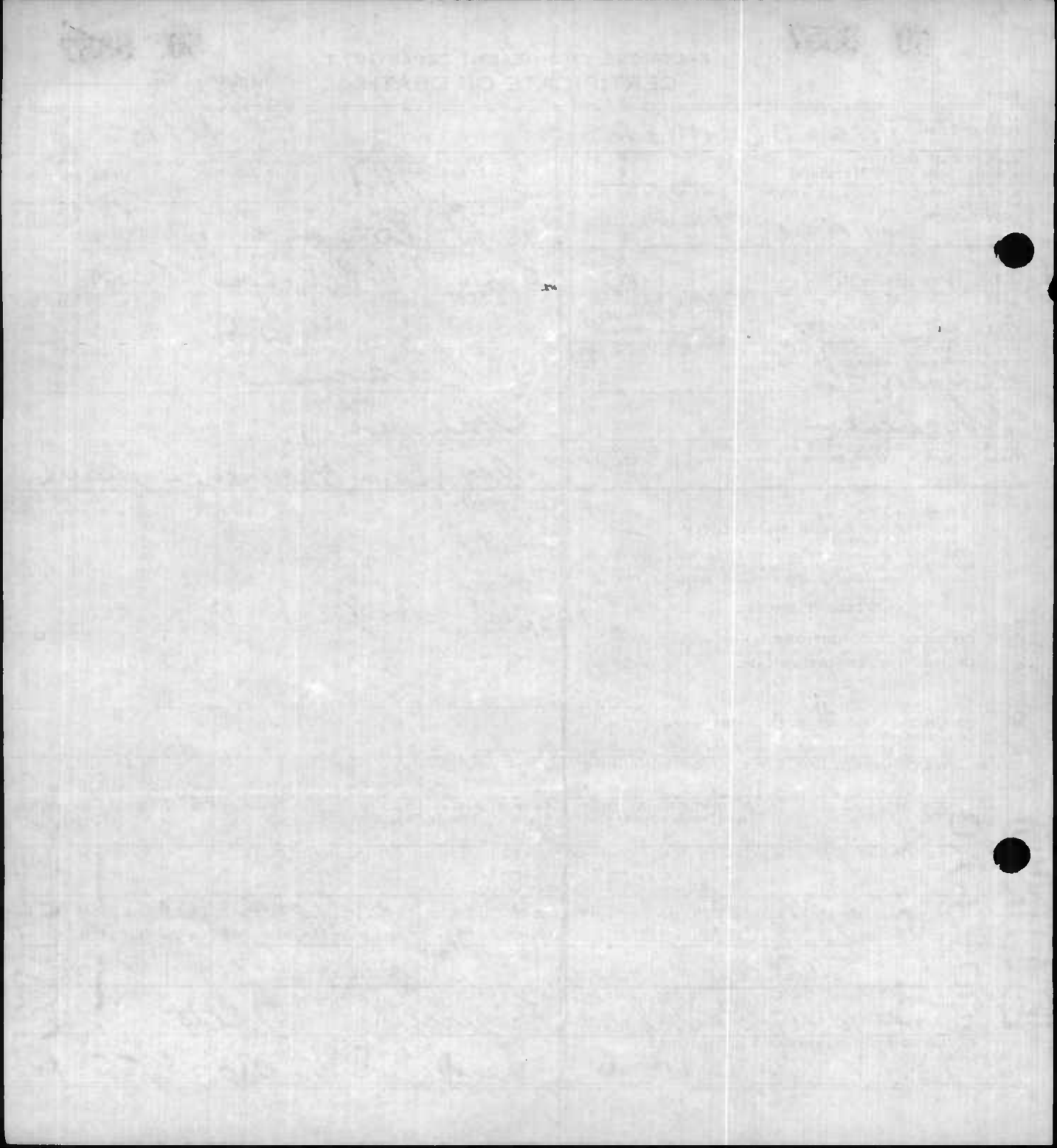
**Sinai Hosp**

**10-16-58**

**Burial 10-17-58 Hebrew Friendship Bldg Md**

**DATE RECEIVED BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS**

**0611/1958 [Signature] Jack Lewis 2100 Easton Pl**









**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>See Womack</i>			2. DATE OF DEATH <i>October 14, 1950</i>		
3. PLACE OF DEATH A. Baltimore City, Maryland <i>See Room</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution) <b>JONES HOPKINS HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 17-02</i>		
c. Length of stay in Baltimore <i>32</i> Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <i>534 Oxford St.</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>4-2-1901</i>	9. AGE (in years last birthday) <i>49</i>	If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Head Camer</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Contractor</i>		
13. FATHER'S NAME <i>Peter Womack</i>			14. MOTHER'S MAIDEN NAME <i>Rebecca Williams</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no</i>			16. SOCIAL SECURITY NO. <i>21-756321</i>		
17. INFORMANT <b>JONES HOPKINS HOSPITAL</b>			ADDRESS _____		

18. <i>420.1</i> I <i>21-756321</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <i>Myocardial infarction</i> DUE TO ANTECEDENT CAUSES (B) <i>coronary arteriosclerosis</i> DUE TO (C) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (D) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>? Lentic aortic insufficiency</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
--	---

19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *10-14* 1950, to *10-14*, 1950 that I last saw the deceased alive on *10-14*, 1950, and that death occurred at *6:40* p.m., from the causes and on the date stated above.

23A. SIGNATURE <i>Thomas J. Walsh</i> M.D.	23B. ADDRESS <b>JONES HOPKINS HOSPITAL</b>	23C. DATE SIGNED <i>10-15-50</i>
---	---	-------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>10-20-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn</i>	24D. LOCATION (City, town, or county) (State)
--	------------------------------	---	---

DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 17 1950</i>	REGISTRAR'S SIGNATURE <i>W. E. Halstead</i>	25. FUNERAL DIRECTOR <i>W. E. Halstead</i>	ADDRESS <i>918-</i>
--	--	---	------------------------

*970 24 Almid Hill acc.  
030d*

MEDICAL CERTIFICATION

11 108 4 4

363 50 8860

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8860  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WALTER WOODRIDGE

2. DATE  
OF  
DEATH

10-15-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

UNIVERSITY HOSPITAL

Yrs.  
Mos.  
Days

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

MAAHER

10B. KIND OF BUSINESS OR  
INDUSTRY

CLOTHING

13. FATHER'S NAME

EMMETT

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

1903

9. AGE (in years  
last birthday)

47

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

14. MOTHER'S MAIDEN NAME

OLIVIA CRAIG

17. INFORMANT

HOSP. RECORD

ADDRESS

18. 029X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

UREMIA Chn. Nephritis

DUE TO

Gumma of liver

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

CARCINOMATOSIS, PRIMARY SITE UNDET.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

SYPHILIS

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from OCT 1, 1950, to OCT 15, 1950, that I last saw the  
deceased alive on OCT 15, 1950, and that death occurred at 7:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

John W. Leary

M. D.

23B. ADDRESS

211 W. 4th St

23C. DATE SIGNED

10-16-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Oct. 20, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county)

Brooklyn, Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

Joseph L. Rees 1200 McCall St

OCT 17 1950

690 4G

309 Balt' Ind

If possible, please state  
a more definite anatomical  
location of the malignant  
tumor?

See Document File 50-8860  
for autopsy findings

10-26-50

90.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 8861  
Registered No.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print) **HARRY PELHAM**

2. DATE

OF DEATH **October 13, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

**University Hospital**

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

**col. white**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**m**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

**Maryland**

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore**

D. STREET ADDRESS (If rural, give location)

**835 W. Fayette Street**

8. DATE OF BIRTH

**June 9, 1911**

9. AGE (In years last birthday)

**39**

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

**Laborer**

11. BIRTHPLACE (State or foreign country)

**Pa.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Louis Pelham**

14. MOTHER'S MAIDEN NAME

**Blanch Bruce**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. **331X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Subdural hematoma**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

**Unknown**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

**Unknown**

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

**Unknown**

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

m.

21F. HOW DID INJURY OCCUR?

**Unknown**

22. I certify that I took charge of the remains described above, held an **autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒.

23A. SIGNATURE

**Stanley K. Durlacher**

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐  
ASSISTANT MEDICAL EXAMINER.....☒  
MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

**Oct. 13, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**Oct. 17, 1950**

24C. NAME OF CEMETERY OR CREMATORY

**Mt. Calvary**

24D. LOCATION (City, town, or county) (State)

**Brooklyn Md**

DATE RECEIVED BY LOCAL REGISTRAR

**OCT 17 1950**

REGISTRAR'S SIGNATURE

**Joseph L. Russ**

25. FUNERAL DIRECTOR

**Joseph L. Russ**

ADDRESS

**1200 McCullough**

V S 151

97099

83a V Balt, Md

1



50 8862

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8862

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary Susie Waller

2. DATE  
OF  
DEATH

Oct. 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

1601 Carlos Tenace

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 12-05

c. Length of stay in Baltimore

5 1/2 years

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

1610 Carlos Tenace

5. SEX

Female

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

October 6, 1886

9. AGE (In years  
last birthday)11 Under 1 Year  
Months: Days  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel Johnson

14. MOTHER'S MAIDEN NAME

Alice

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Lottie Waller. 1601 Carlos Tenace

18. 154X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Adeno-carcinoma of the rectum 10 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from Sept 25, 1950, to Oct 14, 1950, that I last saw the  
deceased alive on Oct 12, 1950, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Kanas B. Tate

23B. ADDRESS

1501 E. Eager St.

23C. DATE SIGNED

10/17/1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

10-18-1950 Chester Va.

Chester Va.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 17 1950

M. D. 10/17/1950

Mrs. Katie R. Williams

Schweden

Montague Waller

October 1902

1001 Cedar Street  
St. Louis  
Missouri  
United States  
John Waller 1001 Cedar  
St. Louis  
Missouri  
United States

ES-141538 50 8863

50 8863

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James Stevenson		2. DATE OF DEATH 10-15-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Baltimore City Hospitals		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-02	
Length of stay in Baltimore 9 Yrs. Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1007 W. Mulberry Street (23)	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 26, 1876
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Construction	9. AGE (In years last birthday) 73
13. FATHER'S NAME John Stevenson (D)		11. BIRTHPLACE (State or foreign country) South Carolina	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Sevella Brice (D)	
17. INFORMANT		ADDRESS 4940 Records* Balto. City Hospitals Eastern Ave.	

18. 153X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Sigmoid with generalized abdominal metastases  
DUE TO

Unknown

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)  
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION  
9-28-5019B. MAJOR FINDINGS OF OPERATION  
Carcinoma Sigmoid20. AUTOPSY?  
YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-12, 1950, to 10-15, 1950, that I last saw the deceased alive on 10-15, 1950, and that death occurred at 7:50 P.M., from the causes and on the date stated above.

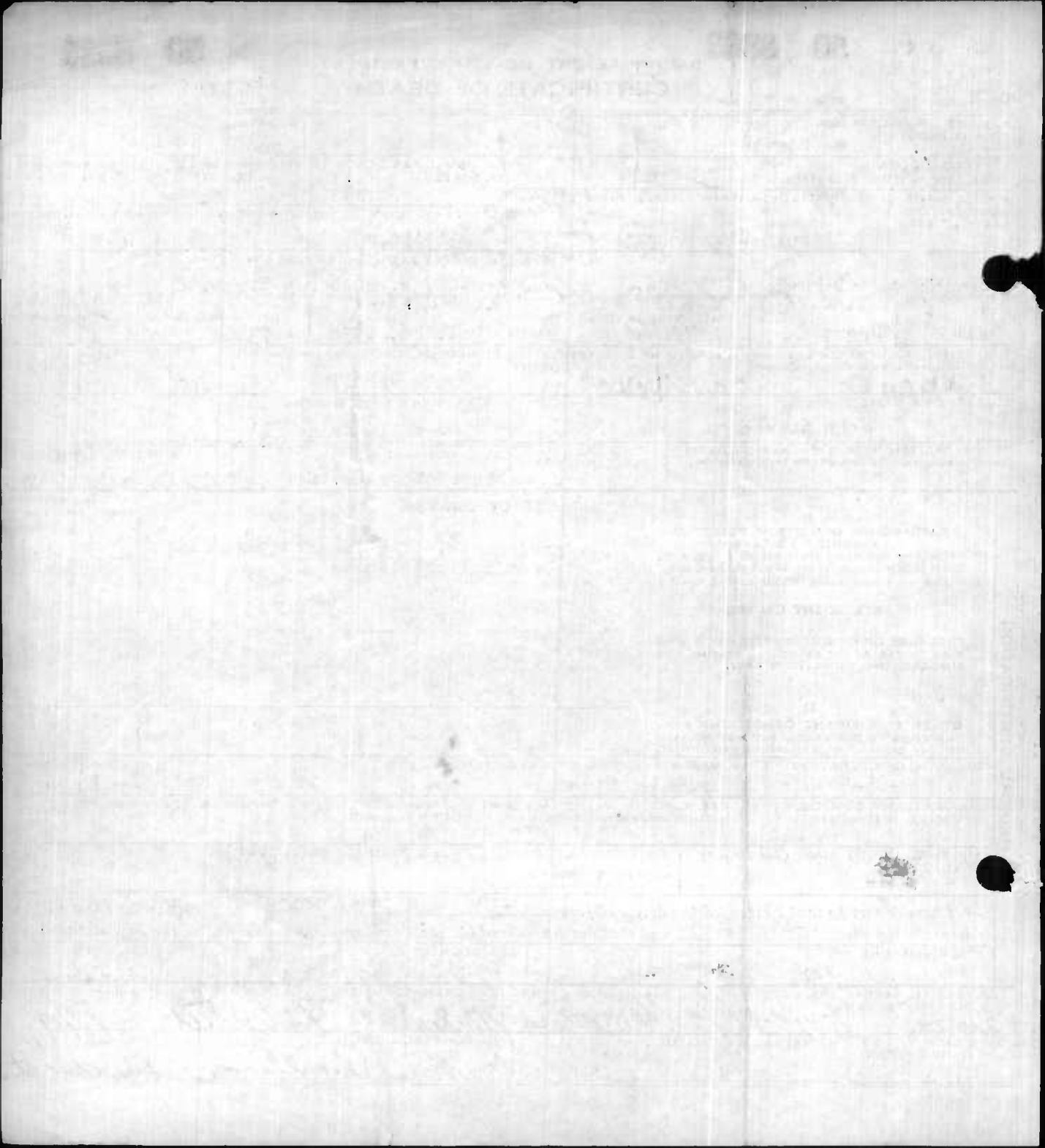
23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial24B. DATE  
10-18-195024C. NAME OF CEMETERY OR CREMATORY  
Bellevue Memorial Park24D. LOCATION (City, town, or county) (State)  
Md.DATE RECEIVED BY LOCAL REGISTRAR  
OCT 17 1950REGISTRAR'S SIGNATURE  
J. Williams25. FUNERAL DIRECTOR  
Mrs. Katie R. Williams

ADDRESS 321 N. Howard St.



50

8864

CERTIFICATE CORRECTED

10-25-50

50

8864

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John F Hunt.

2. DATE  
OF  
DEATH

10-14-50

3. PLACE OF DEATH:  
A. Baltimore City, MarylandB. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

1712 Jackson St

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov 4, 1898

9. AGE (In years  
last birthday)

51-55

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Conductor

10B. KIND OF BUSINESS OR  
INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Lillian Hunt 1712 Jackson St

18. 201X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Hodgkins Disease

Pleural Effusion +  
Myocardial Degeneration

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1, 1950, to Oct 14, 1950, that I last saw the  
deceased alive Oct 13, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 17 1950

VS 150

203 50

0446

20

Idiophanes hesione

Genus of the

Family of the

Order of the

Class of the

Phylum of the

Kingdom of the

Domain of the

Life of the

Idiophanes hesione

Genus of the

Family of the

Order of the

Class of the

Phylum of the

Kingdom of the

Domain of the

Life of the



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>CHARLES EDGAR EATON</b>			2. DATE OF DEATH <b>10/16/50</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MD</b>		
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. JOSEPH'S HOSP.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTO. 13-03</b>		
Length of stay in Baltimore _____ Yrs. Mos. Days			d. STREET ADDRESS (If rural, give location) <b>2645 Pennsylvania Ave</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Jan 14 1883</b>	9. AGE (In years last birthday) <b>67</b>	10. Under 1 Year Months: Days: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Balto Transit Co</b>		
11. FATHER'S NAME <b>Wesley Eaton</b>			12. MOTHER'S MAIDEN NAME <b>Lucretia Palmer</b>		
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			14. SOCIAL SECURITY NO. <b>215-09-3574</b>		
15. INFORMANT <b>Emma H. Eaton</b>			16. ADDRESS <b>2645 Pennsylvania Ave</b>		

18. **420.0**

**CAUSE OF DEATH**

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) **Arteriosclerotic heart disease with acute heart failure**

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

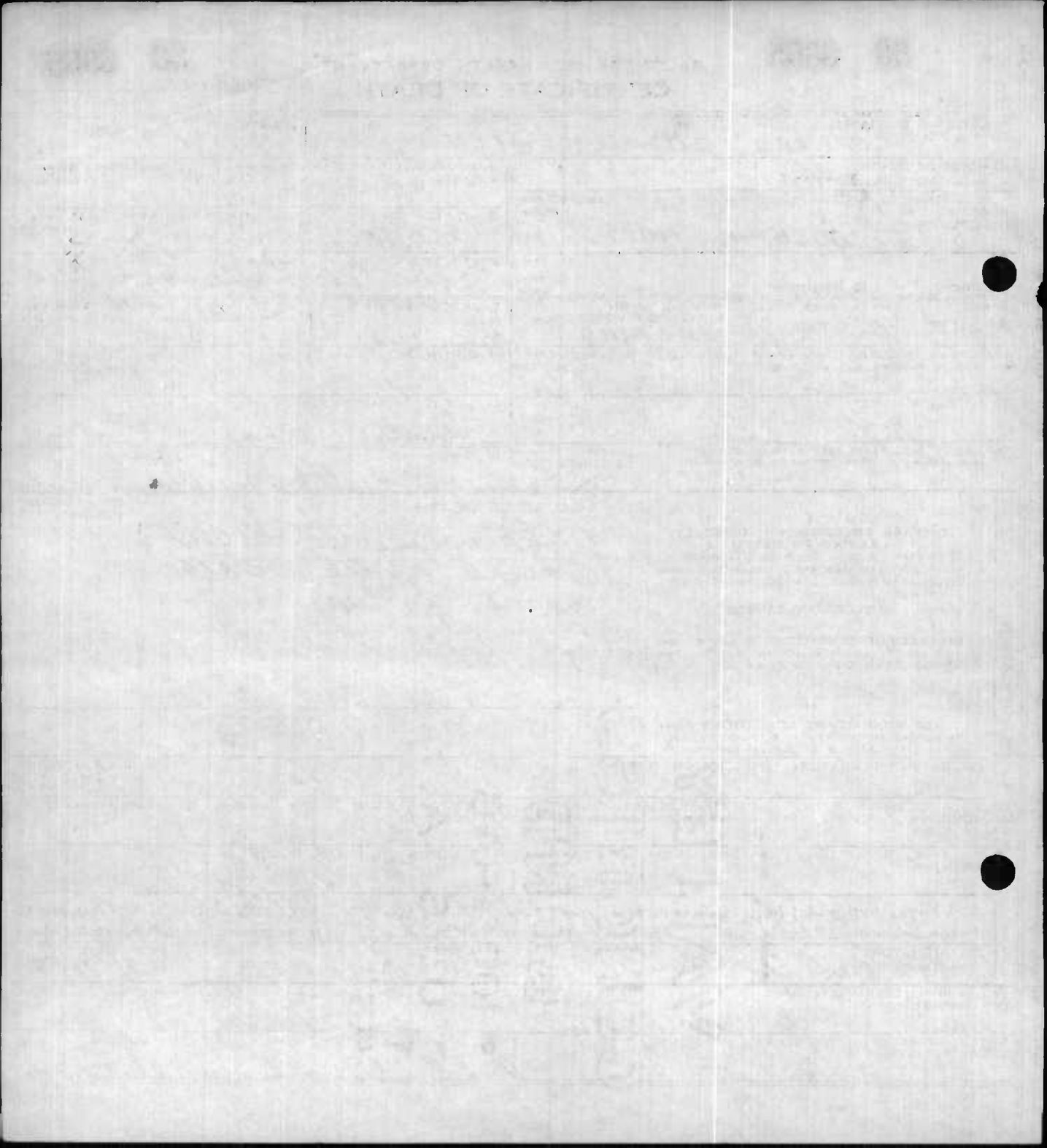
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>10/16/50</b> , to <b>10/16/50</b> , that I last saw the deceased alive on <b>10/16/50</b> , and that death occurred at <b>1:30</b> m., from the causes and on the date stated above.					
23a. SIGNATURE <b>Madeline Swinske</b>		23b. ADDRESS <b>St. Joseph's Hosp.</b>		23c. DATE SIGNED <b>10/16/50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Oct 19, 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Freeland, Md.</b>	
24d. LOCATION (City, town, or county) (State)		24e. FUNERAL DIRECTOR <b>Paul C. Schenck</b>		24f. ADDRESS <b>3615-17 Belmont Ave</b>	

62551

093d

MEDICAL CERTIFICATION

Correct life is especially important. Physicians, please file the cards in their clearly marked group.



**CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Harry W. King

2. DATE  
OF  
DEATH

Oct. 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

613 East 36th Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

613 East 36th Street

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

Dec. 30, 1885-

9. AGE (In years last birthday)

-64-63

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Checker - Classified Ads

10B. KIND OF BUSINESS OR INDUSTRY

Sun Papers

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Samuel King

14. MOTHER'S MAIDEN NAME

Margaret Warner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Estella King, 613 East 36th Street

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

18. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary occlusion

5 years

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

arteriosclerosis

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1940 to Oct 16, 1950, that I last saw the deceased alive on Oct 14, 1950, and that death occurred at 8:00 A.M., from the causes and on the date stated above.

23A. SIGNATURE

H. Strickland

23B. ADDRESS

632 Bouché

23C. DATE SIGNED

Oct 16, 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

10/19/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore,

Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

OCT 17 1950

25. FUNERAL DIRECTOR

Wm. Crook, Inc.

ADDRESS

1217 St. Paul Street

1904

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1904

50 8867

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8867

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frances White

2. DATE  
OF DEATH Oct. 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

5. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

27 N. Carey Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

22-02

D. STREET ADDRESS (If rural, give location)

538 W. Barre Street

6. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

9. AGE (in years  
last birthday)

80

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Kentucky

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Martha Castranda, 538 W. Barre St.

18. 600.0 and 170x

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Uremia

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Chronic pyelonephritis

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.Probable generalized carcinomatosis  
following carcinoma of rt breast in 1948

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from 15 June, 1949, to 15 Oct, 1950, that I last saw the deceased alive on 14 Oct, 1950, and that death occurred at 9 A.M., from the causes and on the date stated above.

22A. SIGNATURE

Emil H. Henning Jr.

M. D.

22B. ADDRESS

601 Winans Way

22C. DATE SIGNED

16 Oct 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

10/13/50

24C. NAME OF CEMETERY OR CREMATORY

St. Peter's

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

H.M. Cook, Inc.

ADDRESS

1217 St. Paul Street

OCT 17 1950

VS 150

050.0

MEDICAL CERTIFICATION

1953 02

1953 02

RECEIVED  
FEBRUARY 1953

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]



543 50 8868

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8868  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Marshall G. Reynolds

2. DATE  
OF  
DEATH

10/14/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

md

B. COUNTY

16-05

C. CITY OR TOWN

Balto

D. STREET ADDRESS (If rural, give location)

839 N. Beutalou St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

5/18/1890

9. AGE (In years  
last birthday)

60

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Auto Mechanic

10B. KIND OF BUSINESS OR  
INDUSTRY

Self

11. BIRTHPLACE (State or foreign country)

Delta, Pa.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Virgil Reynolds

14. MOTHER'S MAIDEN NAME

Margaret (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Marshall F. Reynolds 839 N. Beutalou St.

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

Coronary Thrombosis

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

10 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Arteriosclerotic Cardiovascular Disease

DUE TO

10 yrs.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONITION CAUSING IT.

Thrombosis of right subclavian vein

3 weeks.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

SAPHENOUS

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from 9/25, 1950, to Oct 14, 1950, that I last saw the deceased alive on Oct 14, 1950, and that death occurred at 4 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Albert J. Shuck

M. D.

23B. ADDRESS

2202 Edmond Ave

23C. DATE SIGNED

10/16/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

10/18/50

24C. NAME OF CEMETERY OR CREMATORY

St. Peters

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. H. Cook, Jr.

25. FUNERAL DIRECTOR

ADDRESS

Wm. H. Cook, Jr. 1217 St. Peter St.

OCT 17 1950

VS 150

55083

0932

MEDICAL CERTIFICATION

3000

02

3000

02

*[Faint, illegible handwriting on lined paper]*

140 50 8869

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8869  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Rose Lee Mafale

2. DATE  
OF  
DEATH Oct. 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1018 E. Preston Street

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1018 E. Preston Street

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

July 24, 1885

9. AGE (In years  
last birthday)

65

If Under 1 Year  
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Samuel Trammell

14. MOTHER'S MAIDEN NAME

Amanda ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Joseph Gillespie, 1018 E. Preston St.

18. 150X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Carcinoma of the esophagus  
with multiple wide spread  
metastases

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO  
(C)II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 19, 1950 to 15 Oct, 1950, that I last saw the  
deceased alive on 15 Oct, 1950, and that death occurred at 8:51 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Samuel L. Lyle, M.D.

23B. ADDRESS

714 E. Preston St

23C. DATE SIGNED

16 Oct 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

10/18/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county) (State)

Baltimore,

Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. G. Cook, Inc.

1217 St. Paul Street

OCT 17 1950

VS 150

046a

MEDICAL CERTIFICATION

0000

17

0000

02

350 50 8870

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8870

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Edward Biden, Sr.

2. DATE  
OF  
DEATH

Oct. 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

1445 Covington Street

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)  
Baltimore 24-02

D. STREET ADDRESS (If rural, give location)

1445 Covington Street

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
widowed

8. DATE OF BIRTH

Oct. 10, 1881

9. AGE (In years  
last birthday)

69

If Under 1 Year If Under 24 Hours  
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
Ret. Conductor - Freight10B. KIND OF BUSINESS OR  
INDUSTRY  
B. & O. R.R.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

? Biden

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
no16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. William E. Biden, 5909 Chinguapin Pkwy

18. 150X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Carcinoma of Esophagus

1 yr.

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

9-5-1950

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of lower half esophagus - metastasis in abdo.

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-7, 1949, to 10-16, 1950, that I last saw the  
deceased alive on 10-15, 1950, and that death occurred at 6 A. m., from the causes and on the date stated above.

23A. SIGNATURE

R. J. Fullod

23B. ADDRESS

M. D. 707 E. Fort Ave.

23C. DATE SIGNED

10-16-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

10/19/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Olivet

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

W. J. Williams, Jr.

25. FUNERAL DIRECTOR

Wm. Cook, Inc.

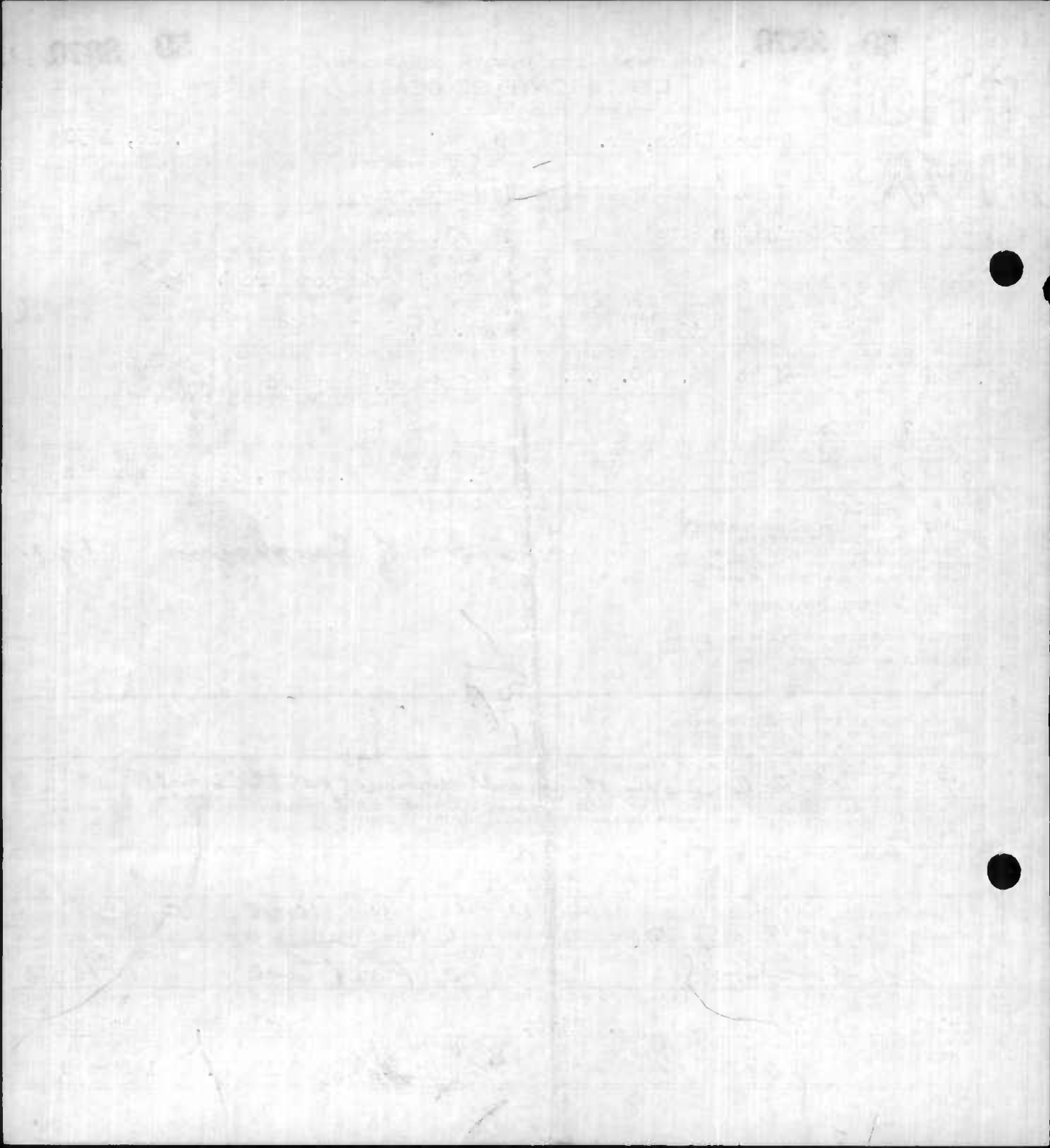
ADDRESS

1217 St. Paul Street

VS 150

203 50

046a





50 8872

50 8872

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Martha E. McGowan

2. DATE  
OF  
DEATH

10-16-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Jenkins Mem. Hosp.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Jenkins Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Jenkins Mem.

Length of stay in Baltimore

89

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

None

13. FATHER'S NAME

John T. Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

no

17. INFORMANT

ADDRESS

Joseph McGowan - 2212 Potholite

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)(A) HYPERTENSIVE CARDIO-  
DUE TO VASCULAR DISEASE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CONGESTIVE FAILURE  
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) GENERALIZED ARTERIOSCLEROSIS

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1, 1950 to 10/16, 1950, that I last saw the deceased alive on 10/16, 1950, and that death occurred at 2:50 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

10/19/50

New Cathedral Cem.

Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 17 1950

Wm. J. Dickens &amp; Sons - Balto Md

093d

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

1908 07

THE STATE OF NEW YORK

IN SENATE

1908 07

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 1, 1907  
ALBANY: J. B. LEECH, STATE PRINTER, 1908.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

MARY MARGARET BERG

2. DATE  
OF  
DEATH

Oct. 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE Md. B. COUNTY Balto.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION 724 W. Fayette St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Balto. 4-02

Length of stay in Baltimore unknown  
Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ Days \_\_\_\_\_

D. STREET ADDRESS (If rural, give location)  
724 W. Fayette St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
widowed

8. DATE OF BIRTH

Nov. ?

9. AGE (In years last birthday)

about 61

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Housewife

10B. KIND OF BUSINESS OR INDUSTRY  
-

11. BIRTHPLACE (State or foreign country)  
Lithuania

12. CITIZEN OF WHAT COUNTRY?  
unknown

13. FATHER'S NAME

Paul Yoskosky

14. MOTHER'S MAIDEN NAME

Mary Kazlauskas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
no

16. SOCIAL SECURITY NO.  
\_\_\_\_\_

17. INFORMANT ADDRESS  
Mrs. Marie R. Bailey 36 N. Bernice Ave.

18. 174X

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of uterus  
DUE TO

years

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_  
DUE TO  
(C) Arteriosclerotic C.V.D.

years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from about, 1949, to Oct. 15, 1950, that I last saw the deceased alive on Oct 13, 1950, and that death occurred at 1 P. m., from the causes and on the date stated above.

23A. SIGNATURE

H. Highstein

M. D.

23B. ADDRESS

888 W. Lombard St.

23C. DATE SIGNED

10-16-50

24A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

24B. DATE

10/18/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county) (State)

Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

8/8. J. Zickner & Sons - Balto Md.

ADDRESS

0486



452  
50 8873BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8873  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		ANNA L. K. SCHLEUNES		2. DATE OF DEATH Oct. 15, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3520 N. Hilton Rd.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-11			
Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 3520 N. Hilton Rd.			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) divorced	8. DATE OF BIRTH June 3, 1868	9. AGE (in years, last birthday) 82	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Christian Schleunes		14. MOTHER'S MAIDEN NAME Mattie Noll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT ADDRESS Mr. J. Louis Raap - 215 N. Charles St.	

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Cardio vascular disease  
DUE TO9/21/49  
to 10/15/50

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) advanced arterio sclerosis  
DUE TO

?

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9/21/49, 19__, to 10/15/50, 19__, that I last saw the deceased alive on 10/5/50, 19__, and that death occurred at __ m., from the causes and on the date stated above.					
23A. SIGNATURE Charles S. Dabbert		23B. ADDRESS M. D. 2220 Garrison Blvd.		23C. DATE SIGNED Oct 16/50	

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/18/50	24C. NAME OF CEMETERY OR CREMATORY Lorraine Cem.	24D. LOCATION (City, town, or county) (State) Woodlawn, Md.
DATE RECEIVED BY LOCAL REGISTRAR OCT 17 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR [Signature]	ADDRESS

2528 07

2528 07

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used to analyze the data, and the results of the analysis. The third part of the report is a discussion of the results of the study and their implications. This includes a comparison of the results with previous studies and a discussion of the limitations of the study. The final part of the report is a conclusion and a list of references.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*John E. Colvin*

2. DATE  
OF  
DEATH

*Oct. 16, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*1215 W. North Ave.*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *Maryland.*

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore*

*14-03*

D. STREET ADDRESS (If rural, give location)

*1215 W. North Ave.*

Length of stay in Baltimore

5. SEX

*Male White*

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*MARRIED*

8. DATE OF BIRTH

*June 20, 1896*

9. AGE (in years last birthday)

*54*

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Marine Engineer*

10B. KIND OF BUSINESS OR INDUSTRY

*Merchant Marine*

11. BIRTHPLACE (State or foreign country)

*La Porte - Iowa*

12. CITIZEN OF WHAT COUNTRY?

*USA*

13. FATHER'S NAME

*Clark Colvin*

14. MOTHER'S MAIDEN NAME

*Unknown*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

*Yes*

(If yes, give war or dates of service)

*WW I*

16. SOCIAL SECURITY NO.

*460-01-2952*

17. INFORMANT

*Emily R. Colvin*

ADDRESS

*- Same*

18. *420.1*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*Coronary Thrombosis*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*Wm. H. Kammmer, Jr.*

23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER.....

23C. DATE SIGNED *Oct. 16, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*Oct. 19-1950*

24C. NAME OF CEMETERY OR CREMATORY

*New Kirk Cemetery New Kirk - Oklahoma*

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

*Oct 17 1950*

REGISTRAR'S SIGNATURE

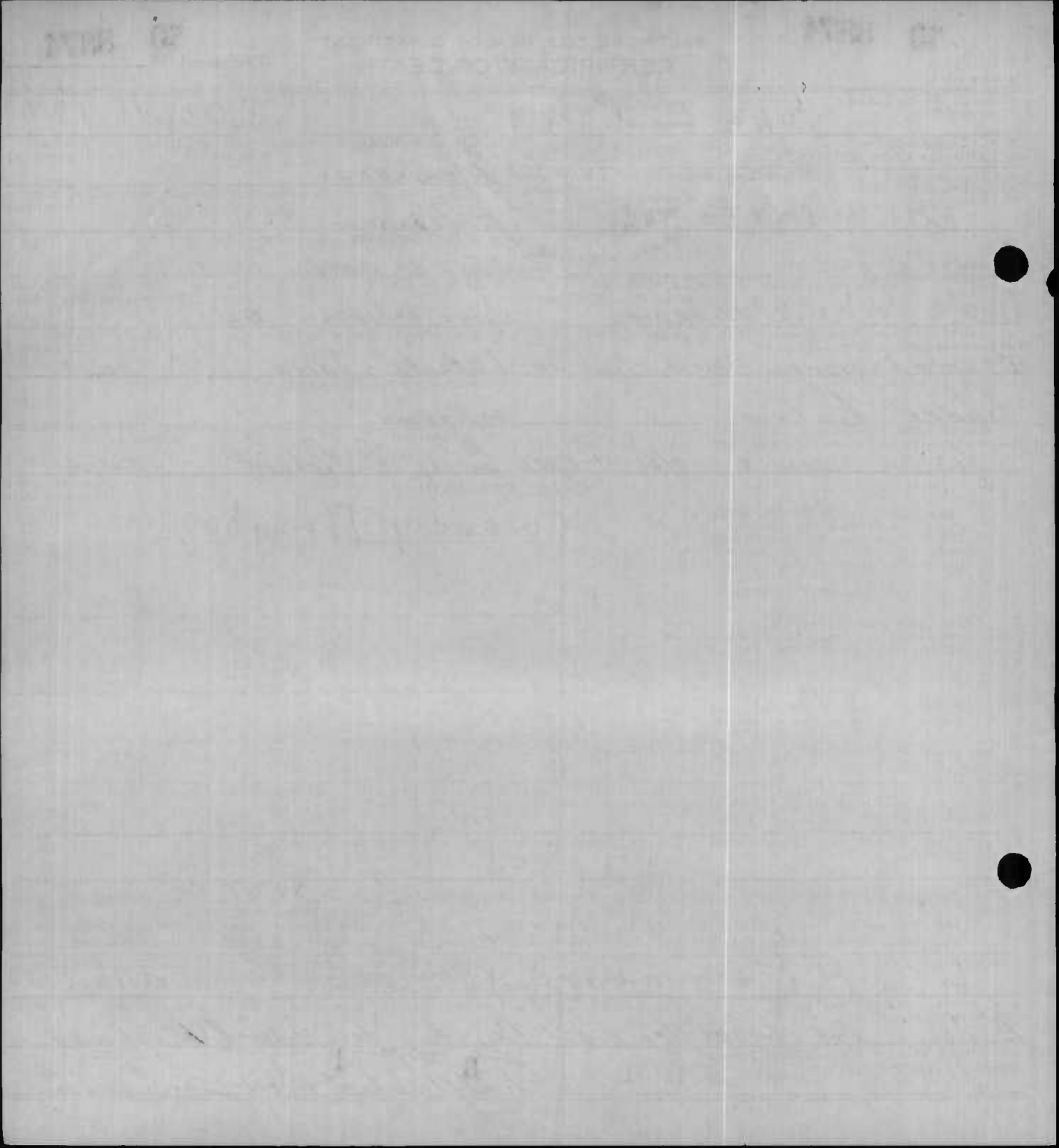
*William H. Kammmer, Jr.*

25. FUNERAL DIRECTOR

*W. H. Kammmer, Jr.*

ADDRESS

*1215 W. North Ave.*



L-251  
50 8875

For APPROVAL BY MED. EX.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8875

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Daisy Lugenbeel

2. DATE  
OF  
DEATH8- P.M.  
Oct. 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

St. Agnes Hospital

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Md.

B. COUNTY

Baltimore

C. CITY OR TOWN

Lonsdowne

D. STREET ADDRESS (If rural, give location)

2919 Charleston Ave 5300

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

8/2

9. AGE (In years  
last birthday)

76

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Home Duties

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

(Md.) Howard Co.

12. CITIZEN OF  
WHAT COUNTRY?

U.S. State

13. FATHER'S NAME

- Blackburn

14. MOTHER'S MAIDEN NAME

Mary Flipsley-Howard Co. Md.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

George W. Lugenbeel - Lonsdowne Md.

18. 422, 1 and E9020

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.(A) ARTERIO-SCLEROTIC CARDIO-  
VASCULAR DISEASE  
(B) E PULMONARY CONGESTION  
(C) FRACTURE BOTH WRISTS -

CERTIFICATION APPROVED BY

R. J. Fisher

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

accident

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

HOME

21C. WHERE DID ACCIDENT OR INJURY OCCUR?

Front Porch at home

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

10 11 50

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

ON FRONT PORCH - FELL OFF

ROOF

22. I hereby certify that I attended the deceased from 10/11, 1950, to 10/15, 1950, that I last saw the  
deceased alive on 10/15, 1950, and that death occurred at 8:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 18/50

24C. NAME OF CEMETERY OR CREMATORY

Mount View

24D. LOCATION (City, town, or county)

Howard Co. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 15 1950

Eugene C. Syfer - 1600 W. North

186a ave

1972

10

OFFICE OF THE ATTORNEY GENERAL

CERTIFICATE OF DEATH

1972

10



M-632

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8876  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SARAH E. MURDOCK

2. DATE  
OF  
DEATH

OCT. 16-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

2442 Edmondson Ave

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

STATE

B. COUNTY

(If outside corporate limits, write RURAL and give township)

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

9-18-1869

9. AGE (In years last birthday)

81

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Gourley

14. MOTHER'S MAIDEN NAME

Gourley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

The M. Stewart - 1600 Hollins

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic CVD

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Nov, 1943 to Oct 16, 1950 that I last saw the deceased alive on Oct 14, 1950, and that death occurred at 3A m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 15 1950

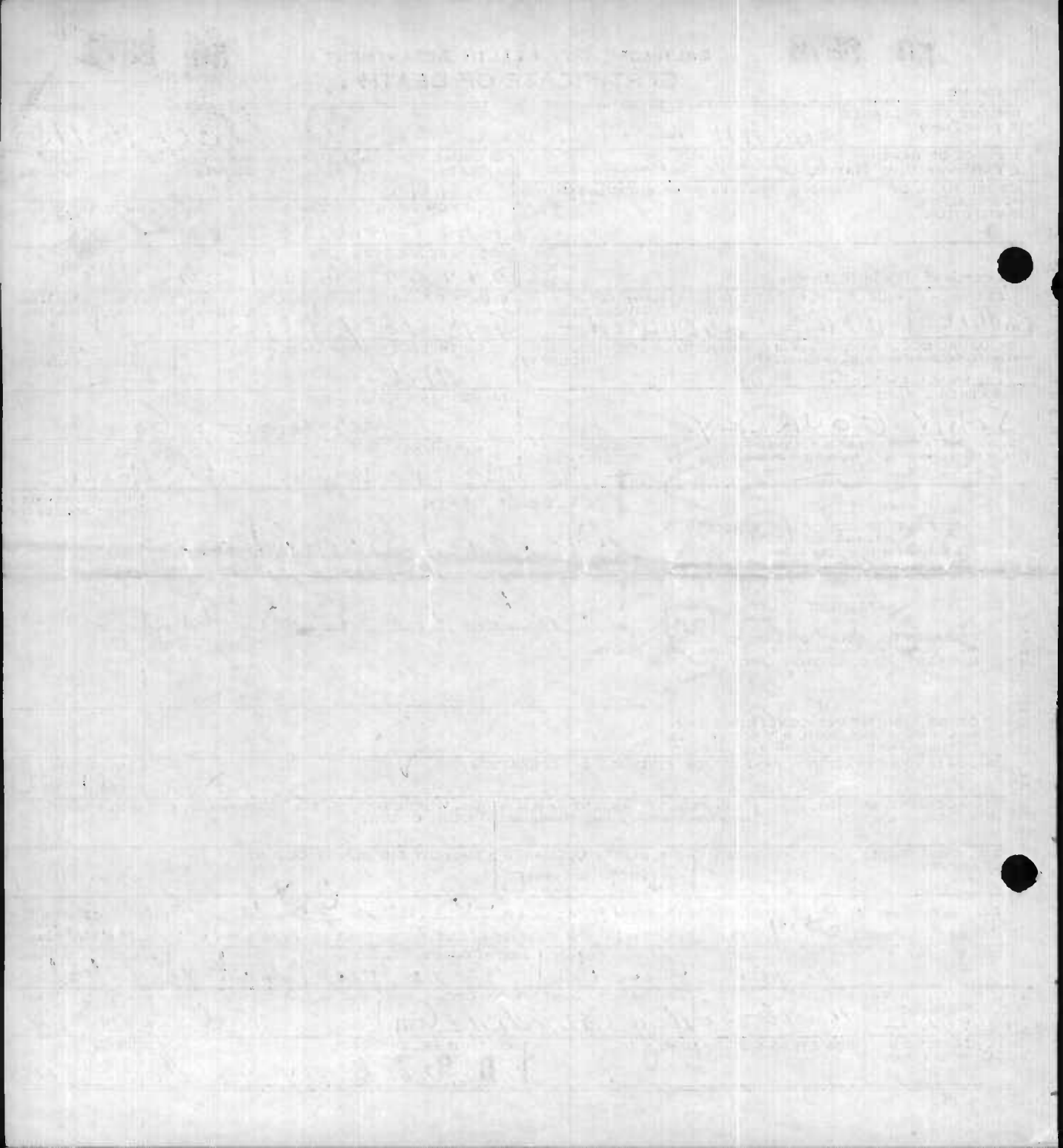
Huntington Williams, M.D.

3325 Frederick Ave 10/16/50  
V. B. BERRY - INC - 1600 Hollins

093d

correct age is especially important. In physicians, please write the causes of death clearly and briefly.

MEDICAL CERTIFICATION





G-432  
50 8877BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8877  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary Goldsborough

2. DATE  
OF  
DEATH

October 13, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

618 George St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

17-01

D. STREET ADDRESS (If rural, give location)

618 George St

E. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Sept. 15, 1875

9. AGE (In years  
last birthday)

75

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR  
INDUSTRY

Maid

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Rachel Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

M's Bertha Hammond

18. 442X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Hypertensive Cardiomyopathy  
Renal Disease

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1950 to Oct 13, 1950, that I last saw the deceased alive on Oct 13, 1950 and that death occurred at 1:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

10-17-50

Mt. Auburn Cem

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 17 1950

VS 150

Wm. J. Williams, M.D.

Wm. Francis T. Hausley

578 W. Biddle St.

1312

1873

DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

1873

VALLEY  
CONDENSED  
BOOKS

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

80-8878

50 8878

B-160-125

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>JANE Pfarr</i>			2. DATE OF DEATH <i>OCT 15 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Halsted - 7</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____		
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>			C. CITY OR TOWN, (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>8-04</i>		
6. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <i>1510 N. Madeira St.</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>5-27-1937</i>		9. AGE (In years last birthday) <i>13</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>George Pfarr</i>			14. MOTHER'S MAIDEN NAME <i>Doris Wolf</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i> ADDRESS _____		

18. *193X and 245X*  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

## CAUSE OF DEATH

(A) *THALAMIC TUMOR*

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

*2 YEARS*

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_

DUE TO

(C) \_\_\_\_\_

11  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <i>Nov 10, 1948</i>		19B. MAJOR FINDINGS OF OPERATION <i>Ventriculogram showed thalamic tumor</i>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *10-14-1950* to *10-15-1950*, that I last saw the deceased alive on *10-15-1950*, and that death occurred at *1:29* m., from the causes and on the date stated above.

23A. SIGNATURE <i>Robert E. Green</i> M. D.	23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	23C. DATE SIGNED <i>Oct. 15, 1950</i>
--	---	--

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Oct 18 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Balto beam</i>	24D. LOCATION (City, town, or county) (State) <i>E North Ave Ext</i>
--	---------------------------------	---	---

DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 17 1950</i>	REGISTRAR'S SIGNATURE <i>Wm. Williams</i>	25. FUNERAL DIRECTOR <i>Lee &amp; Look 1701-03 N. Patterson Park</i>	ADDRESS <i>54 B Ave</i>
--	--	---	----------------------------

NOT to be copied on transcripts -- FOR STATISTICAL PURPOSES ONLY:

Was this a malignant tumor of the brain?  
If so, was this the primary site?  
If secondary, please specify primary site,  
if known.

" **Provisional Anatomical Diagnosis:**

History of sudden death due to ?hypersensitivity to paraldehyde. Pulmonary edema. Neoplasm of the brain. History of left hemiparesis. Muscular atrophy of left half of body with scoliosis to left. Left hydatid of Morgagni and bilateral cysts of the ovaries."

See Document File 50-8878

1/22/1951 ES

Nov

Rare

# CERTIFICATE CORRECTED

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. **5D-8879**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

**RYAN MCGEE**

2. DATE  
OF  
DEATH

**October 14, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland **So. BALto Hosp. DC.**

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE **Baltimore Maryland**

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION **S. Baltimore General**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Maryland 24-04**

D. STREET ADDRESS (If rural, give location)

**1501 Williams ST**

length of stay in Baltimore **3 mos.**

Yrs.  
Mos.  
Days

5. SEX

**M**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**DIVORCED**

8. DATE OF BIRTH

**Aug 14, 1892**

9. AGE (In years last birthday)

**58**

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Machinist**

10B. KIND OF BUSINESS OR INDUSTRY

**Steel Co.**

11. BIRTHPLACE (State or foreign country)

**Darlington S. C.**

12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**Charles Glenn McGee**

14. MOTHER'S MAIDEN NAME

**Annabell (Gray) McGee**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**no veteran**

16. SOCIAL SECURITY NO.

17. INFORMANT

**Son, Walton S.**

ADDRESS

**313 9th St S.E. Wash. D.C.**

18. **420.1**

### CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

**Coronary artery sclerosis**

DUE TO

### ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

### II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Inspection & Inquiry** thereon and from the evidence obtained by said **Autopsy, Inspection or Inquiry**, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

**Stanley H. Dunsicker**

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐

ASSISTANT MEDICAL EXAMINER.....☐

23C. DATE SIGNED

**Oct. 15, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**Oct 19-50**

24C. NAME OF CEMETERY OR CREMATORY

**Washington Natl Cem.**

24D. LOCATION (City, town, or county)

**Scitland, Maryland**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**W. W. Chambers**

25. FUNERAL DIRECTOR

**W. W. Chambers Co.**

ADDRESS

**Washington D.C.**

V 5 OCT 17 1950

544 3A

0942

Correct age is especially important. Physicians, please write the causes of death clearly and fully.

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Nurse

Signature of Chaplain

Signature of Minister

Signature of Priest

Signature of Rabbi

Signature of Imam

Signature of Spiritual Leader

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

50-8880  
W-325

X 50-8880

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>NONA OSSIE WATKINS</b>		2. DATE OF DEATH <b>October 16, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Harford</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>US Marine Hospital</b> <b>Wyman Pk. Drive &amp; 31st St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Havre de Grace</b>	
5. Length of stay in Baltimore <b>20 days</b> Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>3157 Churchville Road</b> <b>6235</b>	
6. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>1/19/10</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>40</b> If Under 1 Year: Months _____ Days _____ If Under 24 Hours: Hours _____ Min. _____
13. FATHER'S NAME <b>Winfield Kesterman</b>		11. BIRTHPLACE (State or foreign country) <b>NC</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>?</b> (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. SOCIAL SECURITY NO. <b>None</b>		14. MOTHER'S MAIDEN NAME <b>Ella Blevins</b>	
17. INFORMANT <b>Records-US Marine Hospital, Balto, Md.</b>		ADDRESS	

18. **434.3**, **416 X**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**Pericarditis, chronic**

CAUSE OF DEATH  
(A) **Pericarditis, chronic**  
DUE TO  
(B) **Postoperative state following partial thoracotomy and pericardectomy**  
DUE TO  
(C) \_\_\_\_\_

INTERVAL BETWEEN ONSET AND DEATH  
**3 yrs.**  
**4 days**

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <b>10/11/50</b>		19B. MAJOR FINDINGS OF OPERATION <b>Pericardial adhesions</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Sept. 26, 1950</b> , to <b>Oct. 16, 1950</b> , that I last saw the deceased alive on <b>Oct. 16, 1950</b> , and that death occurred at <b>6:50A</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>John L. Wilson, Medical Director</b>		23B. ADDRESS <b>US Marine Hospital, Balto, Md.</b>		23C. DATE SIGNED <b>10/16/50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <b>Badgers Funeral Home</b>		24D. LOCATION (City, town, or county) (State) <b>West Jefferson, N.C.</b>	
---	--	-----------	--	---	--	--	--

DATE RECEIVED BY LOCAL REGISTRAR <b>71950</b>		REGISTRAR'S SIGNATURE <b>Howard K. Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Howard K. Williams, M.D.</b>		ADDRESS <b>090B Abingdon, Md.</b>	
--	--	--	--	---	--	--------------------------------------	--

DECLARATION OF DEATH

October 12, 1950

HOME OCCUPATION

Married

US Marine Corps

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married - US Marine Corps

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50-8881

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MACON ST. PAUL BROWN

2. DATE  
OF  
DEATH

October 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Texas

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

S. S. Mobile Field

Maryland Drydock

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Belmont

D. STREET ADDRESS (If rural, give location)

2098 Tulane Street

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan. 4, 1901

9. AGE (In years  
last birthday)

49

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

STEWARDS

10B. KIND OF BUSINESS OR  
INDUSTRY

OIL TANKER

11. BIRTHPLACE (State or foreign country)

Texas

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Jimmie Brown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Ella Brown, Wife, 2098 Tulane Street

**CAUSE OF DEATH**

INTERVAL BETWEEN  
ONSET AND DEATH

18. 420.1

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary occlusion

ANTECEDENT CAUSES

(B) Myocardial infarct

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William H. Welby

23B. CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
M.D. MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

October 16, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct 21 1950

24C. NAME OF CEMETERY OR CREMATORY

Beaumont Texas

24D. LOCATION (City, town, or county)

Texas

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

OCT 17 1950

REGISTRAR'S SIGNATURE

William H. Welby

25. FUNERAL DIRECTOR

John M. Welby 401 S. Chester Street

ADDRESS



50-8882  
H400

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50-8882  
Registered No.

1. NAME OF DECEASED (Type or Print) Mr. Austin Joseph Healy Sn		2. DATE OF DEATH Oct. 17, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-04	
6. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 2103 E. Oliver Street	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 5-1889
9. AGE (In years last birthday) 61		10. UNDER 1 YEAR Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY SELF	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John E. Healy		14. MOTHER'S MAIDEN NAME Laura Bertrand	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Dannie Healy - 2103 E. Oliver St		ADDRESS	
18. 153X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma, metastatic, of lung DUE TO (B) Carcinoma of ascending colon DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 2 mo 1 year			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-14-1950, to 10-17-1950 that I last saw the deceased alive on 10-17-1950, and that death occurred at 8:20AM., from the causes and on the date stated above.			
23A. SIGNATURE John J. Gould		23B. ADDRESS 1400 N. Caroline Street	23C. DATE SIGNED 10-17-50
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE 10-20-50	24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer	24D. LOCATION (City, town, or county) (State) Baltimore Md.
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE Wm. J. Williams	25. FUNERAL DIRECTOR John J. Kelly	ADDRESS 2435 E. Oliver St

MEDICAL CERTIFICATION

OCT 17 1950

574 24

0462

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1911

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

FOR THE YEAR

1910

ALBANY:

1911

PRINTED BY

THE STATE PRINTING OFFICE

ALBANY, N. Y.

1911

1911

1911

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1911



50 8883

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8883

Registered No.

BIRTH NO. 50-24085

1. NAME OF DECEASED (Type or Print) <b>Velma Williams</b>		2. DATE OF DEATH <b>8-19-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>City</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
B. FULL NAME OF (if not in hospital or institution, give street address or location) <b>2812 Denham Circle</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore, 15-52</b>	
D. STREET ADDRESS (If rural, give location) <b>2812 Denham Circle</b>		E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>8-18-50</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>13</b>
13. FATHER'S NAME <b>Robert Williams</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
14. MOTHER'S MAIDEN NAME <b>Pauline Sampson</b>		17. INFORMANT <b>Mother, 2812 Denham Circle</b>	

18. **760.5**

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) **Cerebral Edema.****6 hours**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) **Prematurity**19A. DATE OF OPERATION **0**

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from **8-18**, 19**50**, to **8-19**, 19**50**, that I last saw the deceased alive on **8-18**, 19**50**, and that death occurred at **8:45** p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

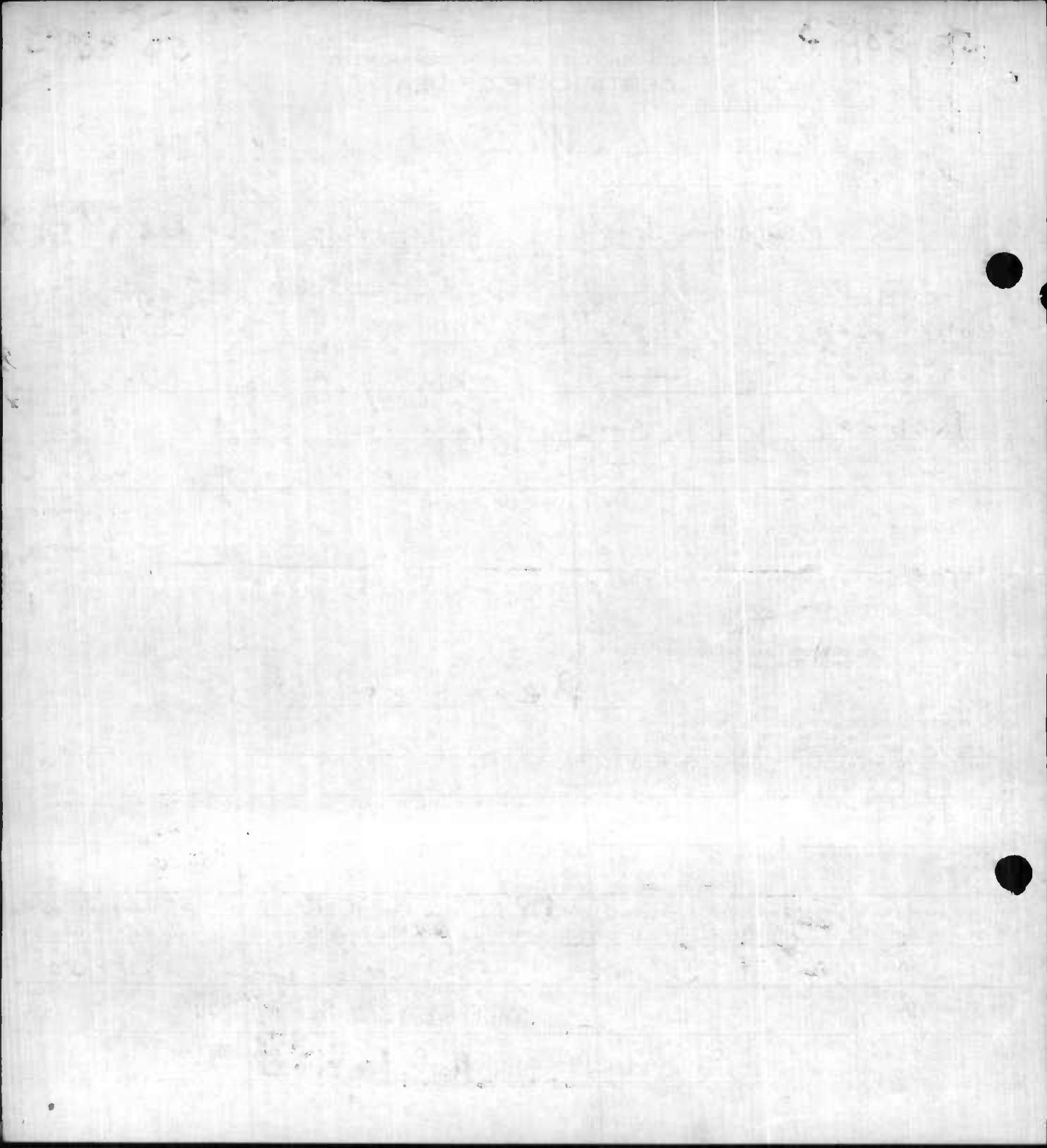
UNIVERSITY MEDICAL SCHOOL SEP 1 1950

Commissioner of Health

VS 150

159

Correct age is especially important. In parentheses, please write the cause of death clearly and briefly.



50-8884

50-8884

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. 50-22234

1. NAME OF DECEASED  
(Type or Print)

Baby Boy Sockrider

2. DATE  
OF  
DEATH

9/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore, Md.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

South Baltimore General Hospital

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

21-01

D. STREET ADDRESS (If rural, give location)

739 McHenry Street

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

9/20/50

9. AGE (In years  
last birthday)10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

8 45

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Edward T. Sockrider

14. MOTHER'S MAIDEN NAME

Sadie Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 770.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Erythroblastosis fetalis - (Icterus jaundice)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 9/20/50, 19\_\_, to 9/21/50, 19\_\_, that I last saw the  
deceased alive on 9/21/50, 19\_\_, and that death occurred at 9:15A. m., from the causes and on the date stated above.

23A. SIGNATURE

J. F. Holister

23B. ADDRESS

M. D.

1212 Light Street

23C. DATE SIGNED

9/21/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

JOHN HOPKINS MEDICAL SCHOOL SEP 25 1950

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

J. F. Holister

25. FUNERAL DIRECTOR

Commissioner of Health

ADDRESS



5-5 CERTIFICATE CORRECTED 11-6-50 FOR APPROVAL BY MED. EX. 50-8885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

I. NAME OF DECEASED  
(Type or Print)

Maxie's Smith

2. DATE  
OF  
DEATH

Oct. 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

A. STATE

B. COUNTY

Maryland

Anne Arundel

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5200

Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

April 7, 1878

9. AGE (In years  
last birthday)

72 3/4

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Knickerbocker

10B. KIND OF BUSINESS OR  
INDUSTRY

Masonry

13. FATHER'S NAME

Louis

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

14. MOTHER'S MAIDEN NAME

Horriet Welch (deid)

17. INFORMANT

Bernard Hardisty, Baltimore Md

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) ACUTE CORONARY  
DUE TO OCCLUSION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) CERTIFICATION APPROVED BY  
Dr. John R. Davis  
per: J. H. Fisher M. D.  
CHIEF OR ASST. MEDICAL EXAMINER.

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the  
deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 5:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 17 1950

VS 150

504 24

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RECEIVED  
JAN 10 1914

41 - 11 - 10

100 - 11 - 10

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100 - 11 - 10

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100 - 11 - 10



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Rudolph T. Wiseman,

2. DATE  
OF  
DEATH

Oct. 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1906 Chelsea Road.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore,

D. STREET ADDRESS (If rural, give location)

1906 Chelsea Road.

Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

Sept. 16, 1867

9. AGE (In years last birthday)

83

10 Under 1 Year Months: Days

11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Hat Finisher,

10B. KIND OF BUSINESS OR INDUSTRY

Hat Factory

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. Frank M. Lentz, 1906 Chelsea Road.

18. 42011

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Arterio Sclerosis - Hypertension

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER- Lying OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☒ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10/2, 1950, to 10/15, 1950, that I last saw the deceased alive on 10/12, 1950, and that death occurred at p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

1337 S. Charles St.

10/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

burial

10/18/50

Holy Cross Cem.

A. A. County, Maryland.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

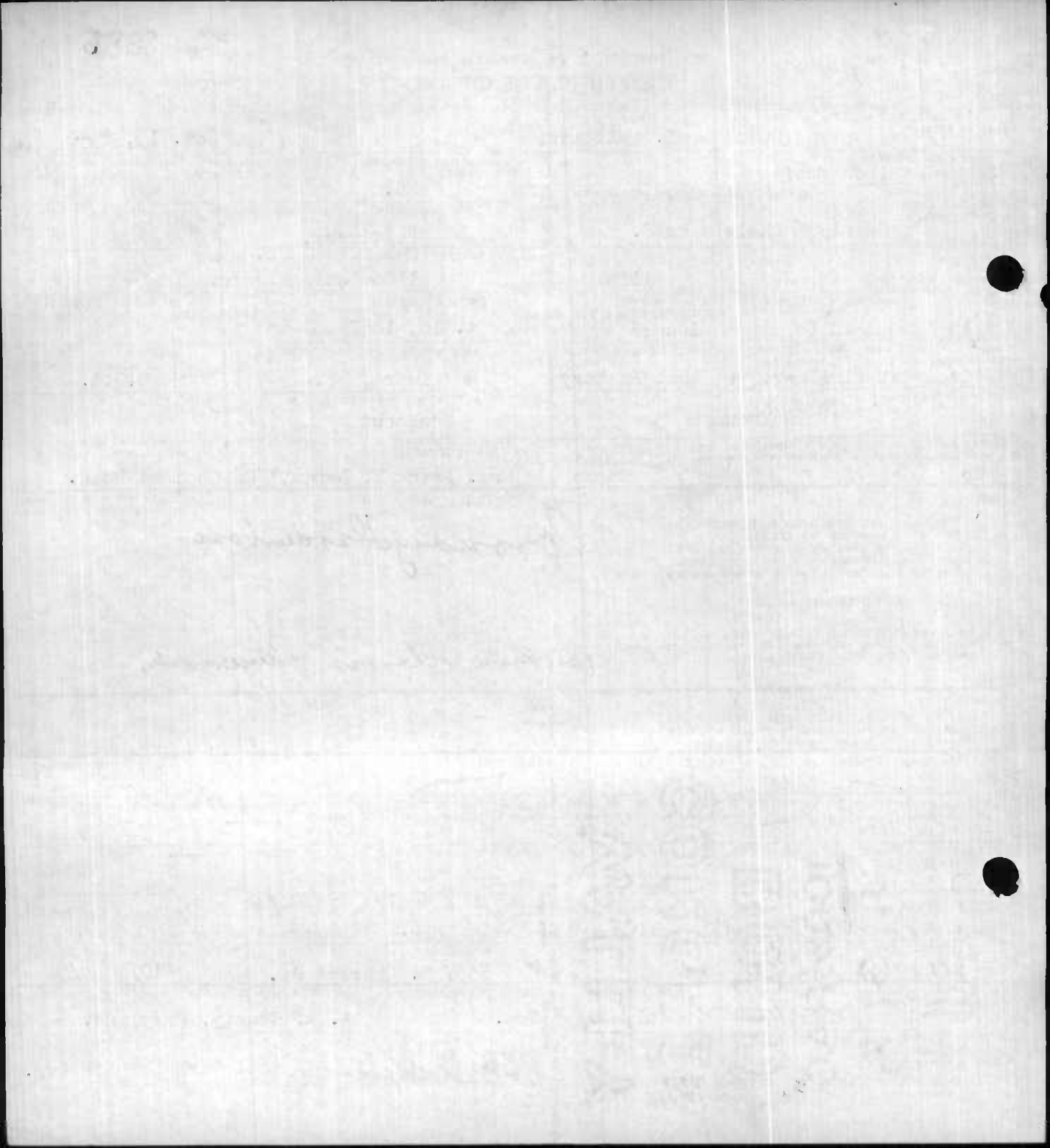
ADDRESS

OCT 17 1950

Y S O O

W. B. Berman & Son

4611 Park Heights Ave.



D-250  
50-8887BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

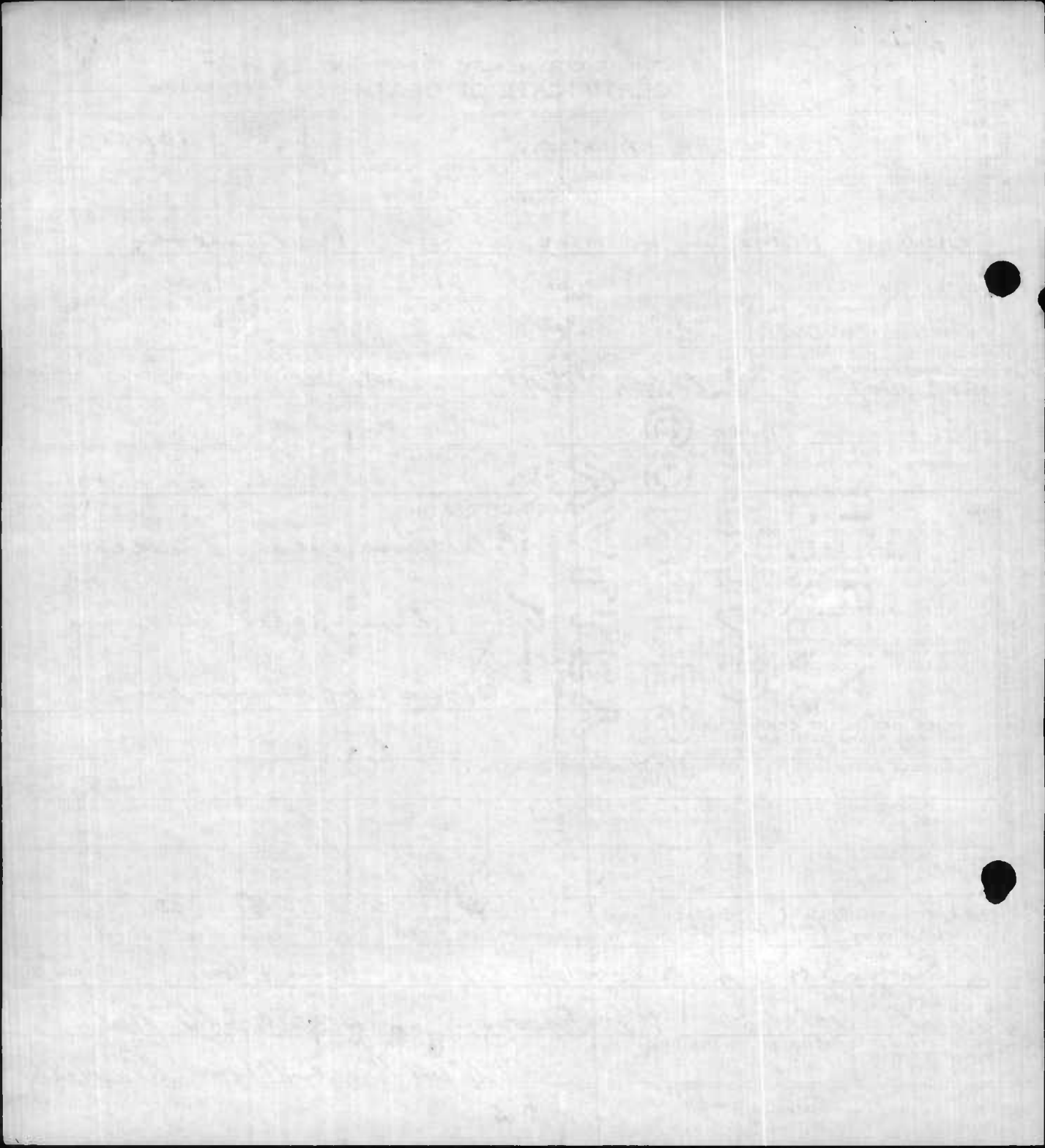
X 50-8887

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ALEXANDER DICKSON</b>		2. DATE OF DEATH <b>10/16/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland ✓		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Ma.</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME &amp; HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore Dundalk</b>	
D. STREET ADDRESS (If rural, give location) <b>21 Dundalk Ave 5300</b>		5. AGE (In years last birthday) Months Days <b>for 8, 1895 55</b>	
6. LENGTH OF STAY IN BALTIMORE <b>30 yrs</b>		7. DATE OF BIRTH <b>for 8, 1895</b>	
8. SEX <b>Male</b>	9. COLOR OR RACE <b>White</b>	10. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	11. AGE (In years last birthday) Months Days <b>55</b>
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		13. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>	
14. FATHER'S NAME <b>Alexander Dickson</b>		15. BIRTHPLACE (State or foreign country) <b>Scotland</b>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>213-09-3540</b>	
18. MOTHER'S MAIDEN NAME <b>Unknown</b>		19. INFORMANT ADDRESS <b>Church Home &amp; Hospice</b>	

18. <b>204.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebrovascular accident.</b>	CAUSE OF DEATH <b>Cerebrovascular accident.</b>	INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Chlor. lymphatic leukemia</b>	DUE TO <b>Chlor. lymphatic leukemia</b>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Brown chop pneumonia</b>	DUE TO <b>Brown chop pneumonia</b>	

19A. DATE OF OPERATION <b>10/14/50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>10/15/50</b>	
22. I hereby certify that I attended the deceased from <b>10/14/50</b> , 19 <b>50</b> , to <b>10/16/50</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>10/15/50</b> , 19 <b>50</b> , and that death occurred at <b>6:20 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Donald J. Heaton</b>		23B. ADDRESS <b>Church Home &amp; Hosp.</b>		23C. DATE SIGNED <b>10/16/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>10/19/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	
24D. LOCATION (City, town, or county) (State) <b>Parkville Md</b>		25. FUNERAL DIRECTOR <b>William J. Williams, Inc.</b>		ADDRESS <b>2112 Dundalk Ave</b>	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50-8888  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>William McMillion</b>		2. DATE OF DEATH <b>Oct. 15, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>348 E. 23 1/2 St.</b>		E. LENGTH OF STAY IN BALTIMORE <b>4 yrs</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Jan. 9 - 1941</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>School Student</b>		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>William McMillion Sr</b>		14. MOTHER'S MAIDEN NAME <b>Ida Bell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Wm McMillion</b>		ADDRESS <b>348 E 23 1/2 St</b>	

18. <b>E 929.8</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Drowning</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B)</b> DUE TO		
<b>(C)</b> DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Jones Falls</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2800 block Falls Rd. 12/7</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>Oct. 15, 1950 abt. 2 P.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell into hole while wading in water</b>	
22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>William J. Smith</b>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>Oct. 16, 1950</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Shipped</b>		24B. DATE <b>10/17-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Clinton N.C.</b>		24D. LOCATION (City, town, or county) (State) <b>N. Carolina N.C.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 17 1950</b>		REGISTRAR'S SIGNATURE <b>William J. Smith</b>		25. FUNERAL DIRECTOR <b>Rayner Sanders</b>		ADDRESS <b>1412 E. Preston St.</b>	

2464



BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
 (Type or Print)

William Walter Wheat

2. DATE  
 OF  
 DEATH

Oct. 16/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
 HOSPITAL OR INSTITUTE

1609 W. Lombard St.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
 A. STATE B. COUNTY

Ma.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
 Baltimore

D. STREET ADDRESS (If rural, give location)

1609 W. Lombard St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

Yrs.  
 Mos.  
 Days

Length of stay in Baltimore

Life

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

-----Wheat

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

Aug. 15, 1870

9. AGE (in years last birthday)

80

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Ma.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Unknown

17. INFORMANT

ADDRESS

Mrs. Etta Price, 1609 W. Lombard St.

18. 450.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
 (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Calmanan Oedema

12 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Chronic Dilatation

3

DUE TO

(C)

Arterio Sclerosis

3

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/4, 1950, to 10/16, 1950, that I last saw the deceased alive on 10/14, 1950, and that death occurred at 5 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

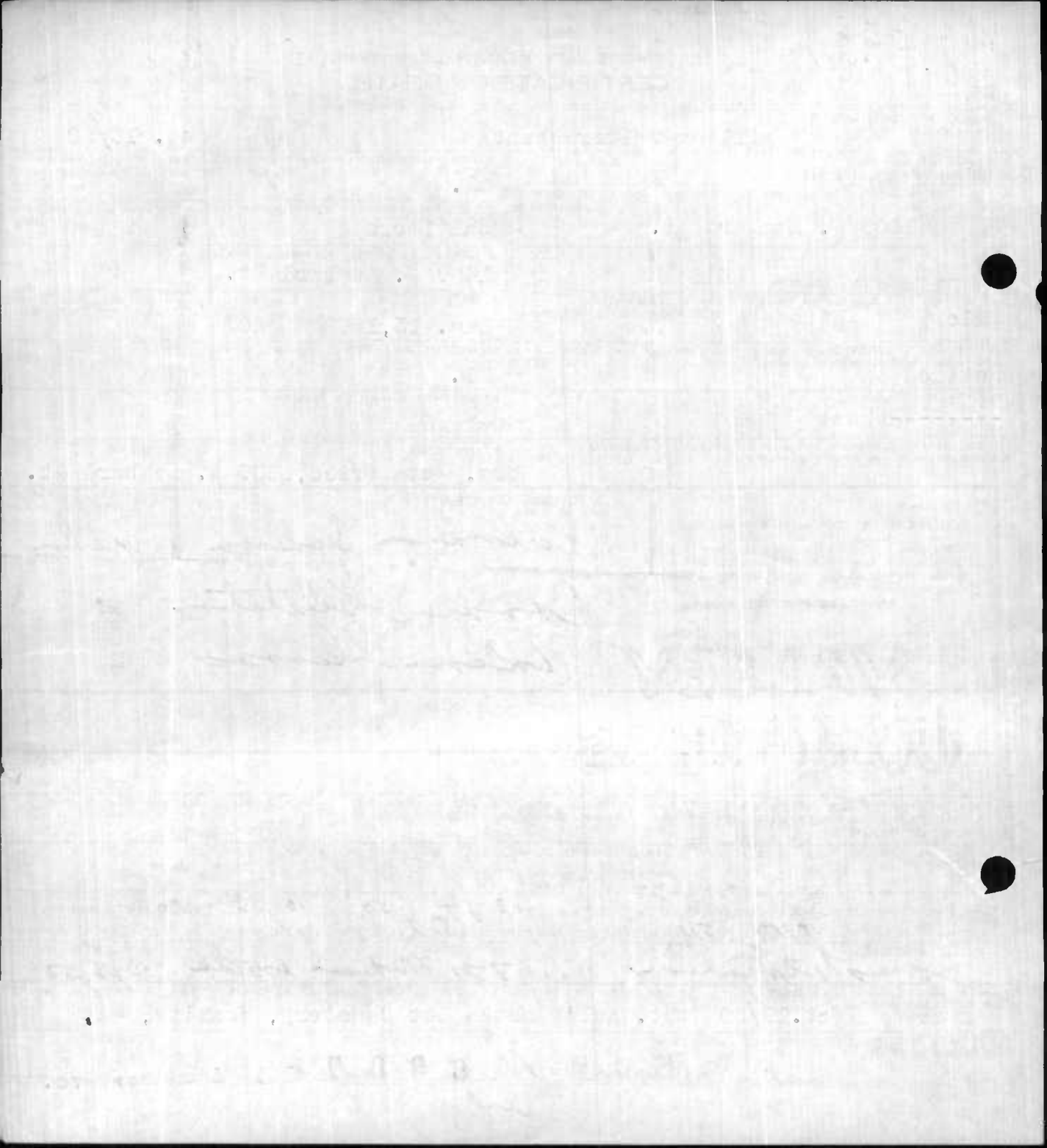
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



H. 550  
50-8890

CERTIFICATE CORRECTED 10-25-50

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50-8890  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Catherine Katherine F. Hohman		2. DATE OF DEATH 10-15-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore		4. USUAL RESIDENCE (Where deceased lived: If institution: residence A. STATE Maryland B. COUNTY before admission)	
B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) INSTITUTION 1650 Ralworth Rd.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give Baltimore 9-02 township)	
Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1650 Ralworth Rd.	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 5-24-1883
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 67
11. BIRTHPLACE (State or foreign country) Nova Scotia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas J. Sheehan		14. MOTHER'S MAIDEN NAME Annie Ferris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-05-2971	
17. INFORMANT Henry W. Hohman		ADDRESS 1650 Ralworth Rd.	

18. 151X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

## CAUSE OF DEATH

(A) Gastric Carcinoma  
DUE TO

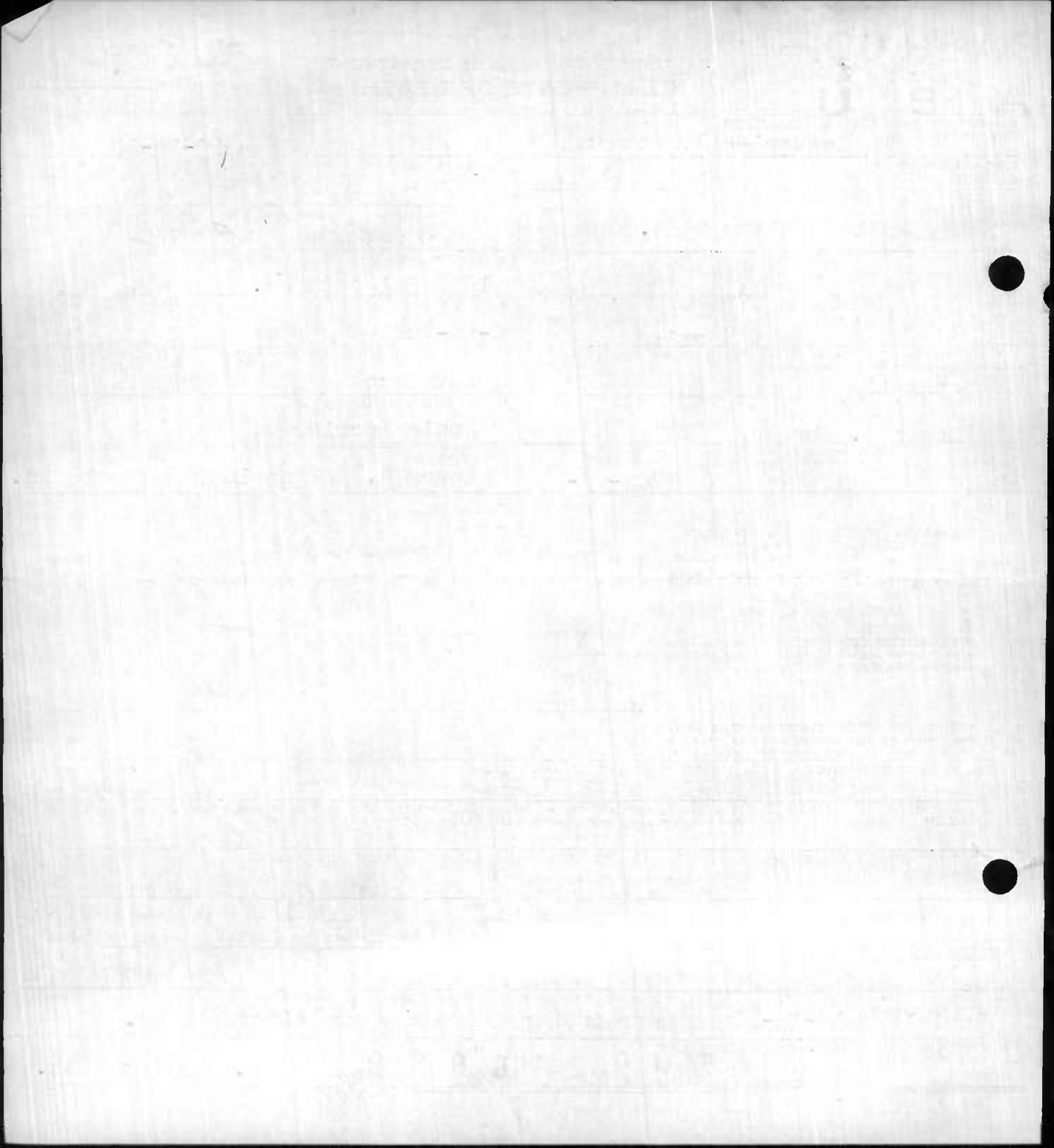
## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TOII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Gall bladder disease

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION 8 Aug - 1950		19B. MAJOR FINDINGS OF OPERATION Gastric Carcinoma		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept 1, 1950, to Oct. 15, 1950, that I last saw the deceased alive on Oct. 15, 1950, and that death occurred at m., from the causes and on the date stated above.					
23A. SIGNATURE Walter A. Anderson		23B. ADDRESS 3001 Shawan Drive (13)		23C. DATE SIGNED Oct 17-50	
24A. BURIAL, CREMA- TION, REMOVAL (Specify) Burial		24B. DATE 10-18-50		24C. NAME OF CEMETERY OR CREMATORY Lorrain Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Md.	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE Walter A. Anderson		25. FUNERAL DIRECTOR John P. Danz 3000 N.B.	
				ADDRESS E. Baltimore St.	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50-8891  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LONA ELDER

2. DATE  
OF  
DEATH

October 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5303 Eastern Avenue

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

10-15-1924

9. AGE (in years last birthday)

26

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Arthur A. Fok

14. MOTHER'S MAIDEN NAME

Sallie Ann Little

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Wayne Elder 5303 Eastern Ave.

18. E823.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushed chest

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Eastern Ave. and North Point Road

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

October 16, 1950 12.20 a.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ran off road and over bank

22. I certify that I took charge of the remains described above, held an INQUIRY thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William Wood

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Oct. 16, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

Oct. 17-1950

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Taylorville North Carolina

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

John J. Connelly, Crick, N.C.

VS 151

N 862.2

170C

correct age is especially important. In any instance, please write the causes of death clearly and fully.

MEDICAL CERTIFICATION





B-635  
50 8892

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

over 50-8892  
50 8892  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Nancy Boardman

2. DATE  
OF  
DEATH

Oct 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Claymont

D. STREET ADDRESS (If rural, give location)

11 Hillside Rd

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Boardman

14. MOTHER'S MAIDEN NAME

Janice Johnston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 754.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Heart disease  
DUE TO Cyanotic type

8 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)  
DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

10-17-50.3

19B. MAJOR FINDINGS OF OPERATION

Congenital heart dis., type undet.

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

III. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10/4, 1950, to 10/17, 1950, that I last saw the deceased alive on 10/17, 1950, and that death occurred at 10/17/50 from the causes and on the date stated above.

23A. SIGNATURE

W. H. Morrow

M. O.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

10-17-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removed

24B. DATE

Oct 17/50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Wilmington Del

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Delaware, Mo

25. FUNERAL DIRECTOR

ADDRESS

Call E. Samuel Home 2008 Olean

10-17-1950

VS 150

Med. & Case to be approved

1572

MEDICAL CERTIFICATION

Just a quick & case.

O/K by Dr. Fisher.

5:40 - P.M. - 10/17/50.

send back to Harp. for sig. & Dr. in ink

420

50

8893

Information in red from birth certificate - JPB  
BALTIMORE CITY HEALTH DEPARTMENT

50

8893

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-18265

1. NAME OF DECEASED  
(Type or Print)

Marian Catherine Roles

2. DATE  
OF  
DEATH

Sept. 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1921 Asquith St.

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

U

S

8. DATE OF BIRTH

U 8-31-50

9. AGE (In years  
last birthday)10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.

14

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

K

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

N

Rudolph Gillett Roles

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

N

17. INFORMANT

W

ADDRESS

N

18. 762.5

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary atelectasis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Prematurity

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23b. CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
MEDICAL INVESTIGATOR23c. DATE SIGNED  
Sept. 1, 195024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

F. FUNERAL DIRECTOR

ADDRESS

THE UNIVERSITY OF CHICAGO  
LIBRARY  
1207 EAST 58TH STREET  
CHICAGO, ILL. 60637  
TEL: 773-936-3700  
FAX: 773-936-3701  
WWW.CHICAGO.EDU  
LIBRARY@CHICAGO.EDU

50

8894

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50

8894

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)2. DATE  
OF  
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCEE (Specify)

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS

(If rural, give location)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months Days  
If Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

30 APR 1981

STATE OF NEW YORK

30 APR 1981





50 8895

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8895

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Christian Wacker

2. DATE  
OF  
DEATH

10.18.50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTO

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

8919 PULASKI HIGHWAY

Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

SEPT 25 1883

9. AGE (In years last birthday)

67

10. Under 1 Year

11. Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

truck farmer

owner

11. BIRTHPLACE (State or foreign country)

USA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHRISTIAN

WACKER

14. MOTHER'S MAIDEN NAME ?

MRS MARY WACKER

ENGLAND

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

(If no, no known)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MRS MARY WACKER

SAME

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HAEMORRHAGE

DUE TO

14 DAYS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) HYPERTENSIVE CARDIOVASCULAR DIS

DUE TO

YEARS

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 6.12.1950 to 10.18.1950, that I last saw the deceased alive on 10.17.1950, and that death occurred at 12.30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Dorance Hushberg

M. D.

23B. ADDRESS

CHURCH HOME &amp; HOSPITAL

23C. DATE SIGNED

10.18.50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

10/21/50

LAW LUTH CAM

BALTO CO

MD

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 18 1950

Funeral Home

Funeral Home 7401 Blain Rd

VS 150

10010

093d

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

RECEIVED  
JAN 1 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.  
OFFICE OF THE SECRETARY  
SAC, NEW YORK  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or letter containing several paragraphs of text, possibly discussing a case or administrative matter. Key words like "SAC", "FROM", and "SUBJECT" are visible at the top of the main body of text.]

560  
50 8896BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8896

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mr. John Sommer

2. DATE  
OF  
DEATH

10-16-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Md.

B. COUNTY

Balto. Co

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Overlea 5200

D. STREET ADDRESS (If rural, give location)

8607 Belair Rd.

C. Length of stay in Baltimore

1 Day

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

11-7-73

9. AGE (In years  
last birthday)

76

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

Nursery

11. BIRTHPLACE (State or foreign country)

Balto.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Sommer

14. MOTHER'S MAIDEN NAME

Katherine Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs John H. Sommer 8607 Belair Rd

18. 446x

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Uremia

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Nephrosclerosis

DUE TO

(C)

Arterial Hypertension

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-16, 1950 to 10-16, 1950, that I last saw the  
deceased alive on 10-16, 1950, and that death occurred at 6:10 pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

10/20/50

Paxwood

Balto Co

Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 18 1950

VS 150

Lanahan Funeral Home 7401 Belair Rd Md

131a

Amelia H.

Ehrhardt

50 8897

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8897  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WALTER

EDWARD

KUCHAREK, JR.

2. DATE  
OF  
DEATH

October 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Baltimore City Hospital

Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Oct. 25, 1934

9. AGE (In years  
last birthday)

15

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR  
INDUSTRY

Patterson High School

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Walter Edward Kucharek, Sr.

14. MOTHER'S MAIDEN NAME

Cecelia Oszakiewski

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Walter E. Kucharek 922 S. Robinson St.

18. E812.4

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Fractured skull

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Intracranial hemorrhage

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)  
Street21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Dundalk &amp; Holabird Aves., Balto. Co., Md.

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

October 14, 1950 9:20 P. m.

21E. INJURY OCCURRED  
WHILE AT NOT WHILE ☒  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

5300

22. I certify that I took charge of the remains described above, held an Partial autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER  
ASSISTANT MEDICAL EXAMINER  
MEDICAL INVESTIGATOR23C. DATE SIGNED  
10-17-5024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct 19-1950

24C. NAME OF CEMETERY

Holy Rosary

24D. LOCATION (City, town, or county) (State)

Baltimore Co, Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

V S 151

N 803.2

170 C

Correct age is especially important in infant deaths - please write the cause of death clearly and fully.

MEDICAL CERTIFICATION





520  
50 8898BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8898

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Walter Semski

2. DATE  
OF  
DEATH

Oct 12/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore  
Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OF RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

4. USUAL RESIDENCE (Where deceased lived, if institution, residence

A. STATE

Md

B. COUNTY

before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give

Baltimore 2-03

township)

D. STREET ADDRESS (If rural, give location)

1816 Fleet St

8. DATE OF BIRTH

11-6-06

9. AGE (In years

last birthday)

43

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

ELECTRICAL SUP.

10B. KIND OF BUSINESS OR  
INDUSTRY

DRY DOCK

13. FATHER'S NAME

Michael Semski

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Frances Lohinski

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

YES 214/03/2179

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 581.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Hemorrhage from Ruptured 2h.

DUE TO Esophageal Varices.

(B) Cirrhosis of the Liver 2 yrs

DUE TO Chronic Alcoholism yrs

(C)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

M.

WHILE AT

WORK ☐

NOT WHILE

AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/5, 1950 to 10/17, 1950, that I last saw the  
deceased alive on 10/17, 1950, and that death occurred at 12:00 m., from the causes and on the date stated above.

23A. SIGNATURE

David J. Jenkins

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

10-17-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct 21-1950

24C. NAME OF CEMETERY OR CREMATORY

St Stanislaus

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Edw. E. Weber 705 S. Anne

ADDRESS

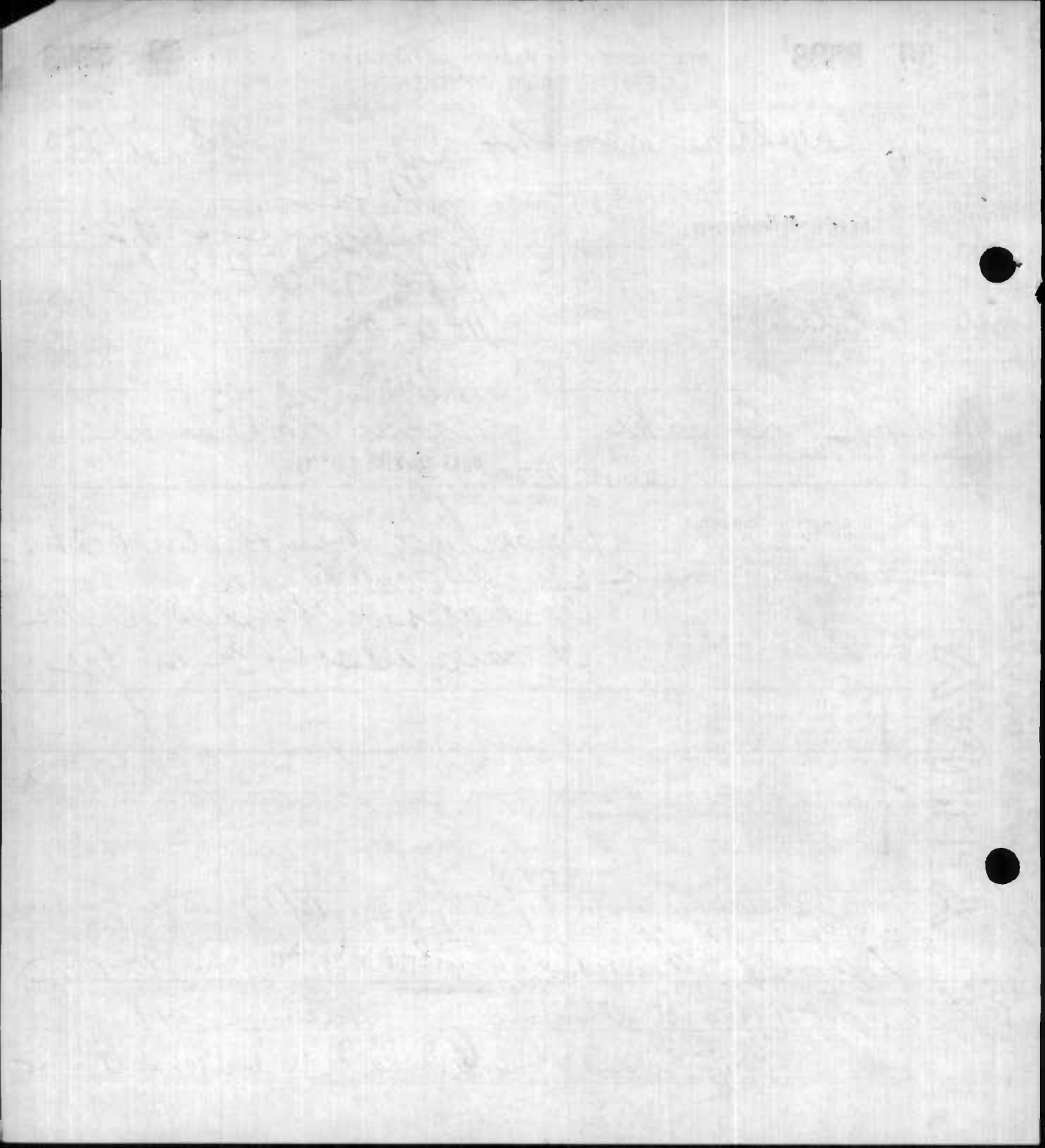
OCT 18 1950

VS 150

096 3U

124a

MEDICAL CERTIFICATION



50 8899

JL- 39751

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8899

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Vincent Leweik

2. DATE  
OF  
DEATH

10-8-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street address or location)  
Baltimore City Hospitals  
4940 Eastern Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

26-12

D. STREET ADDRESS (If rural, give location)

No Home address

C. Length of stay in Baltimore

12 yrs.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Wid.

8. DATE OF BIRTH

Jan. 6, 1860

9. AGE (In years  
last birthday)

90

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Michael Leweik

14. MOTHER'S MAIDEN NAME

Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

B. C. H. Records, 4940 Eastern Ave.

18. 450.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerosis generalized

DUE TO

Years

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

10-6-50

19B. MAJOR FINDINGS OF OPERATION

Gangrene of left foot and lower leg

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-7, 1950, to Oct. 8, 1950 that I last saw the  
deceased alive on Oct. 8, 1950 and that death occurred at 1.55AM., from the causes and on the date stated above.

23A. SIGNATURE

W. Cogan

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

10-17-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

10/18/50

24C. NAME OF CEMETERY OR CREMATORY

Sacred Heart

24D. LOCATION (City, town, or county)

German Hill Rd

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

W. Cogan

25. FUNERAL DIRECTOR

ADDRESS

John J. Bailey &amp; Sons

1318 Sig St. S.E.

097.0

VS 150

MEDICAL CERTIFICATION

1950

STATE OF NEW YORK

1950

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

530  
50 8900BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 8900

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Merle Bond

2. DATE  
OF  
DEATH

October 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

Peekinaton

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

Female White

Single

1-29-38

12

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

Miss.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Lois Blackwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 754.4

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Congenital heart disease,  
cyanotic type.

Congenital

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

10-16-50

19B. MAJOR FINDINGS OF OPERATION

Probable pulmonary stenosis

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-12, 1950, to 10-17, 1950, that I last saw the  
deceased alive on 10-17, 1950, and that death occurred at 5 P. m., from the causes and on the date stated above.

23A. SIGNATURE

J. B. Morrow

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

10-17-50

24A. BODILY CREMA-  
TION REMOVAL (Specify)

Removal

24B. DATE

10/14/50

24C. NAME OF CEMETERY OR CREMATORY

Paramount

24D. LOCATION (City, town, or county)

Stone Co. Miss.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

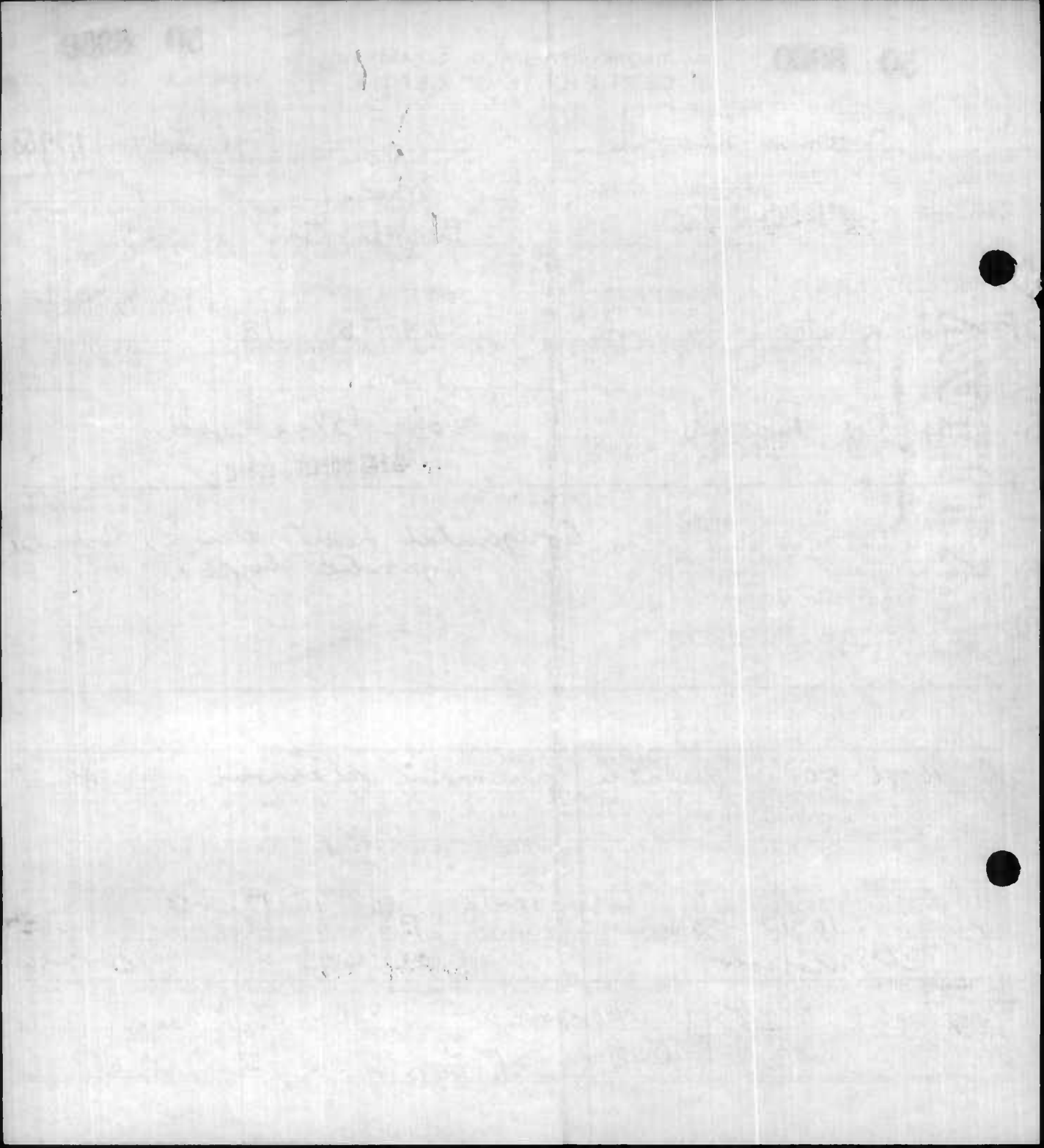
REGISTRAR'S SIGNATURE

Wilmington Williams

25. FUNERAL DIRECTOR

ADDRESS

118 E. Prof. Inc. 1217 St. Paul St.





50 8901

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8901  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Anna - C. Fonohue

2. DATE  
OF  
DEATH

Oct 16 - 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland B alto

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2862 Mayfield ave

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE Md B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
B alto 8-01

D. STREET ADDRESS (If rural, give location)

2862 Mayfield ave

Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Wife

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

John H. Williams

8. DATE OF BIRTH

May 3 - 1881

9. AGE (in years last birthday)

69

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

B alto

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

(Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Bertha Long - 2862 Mayfield ave

18. 422.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral hemorrhage

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Arteriosclerotic cardio-vascular disease

5 yrs

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1946, 19 to Oct. 16, 1950, that I last saw the deceased alive on Oct. 14, 1950 and that death occurred at 11 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Dorothy H. Todd

M. D.

23B. ADDRESS

2108 St. Paul St

23C. DATE SIGNED

10/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct 19-50

24C. NAME OF CEMETERY OR CREMATORY

B alto Cemetery

24D. LOCATION (City, town, or county)

B alto

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

OCT 18 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

10290 Ave 100

ADDRESS

3001 Kentucky ave

093d

1004 87

1004 87

2108 St Paul St

50 8902

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8902  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Janet Small Hepburn

2. DATE OF DEATH  
Oct. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland none

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

128 W. 24th St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

12-07

D. STREET ADDRESS (If rural, give location)

128 W. 24th St.

Length of stay in Baltimore

life Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Sept. 19, 1883

9. AGE (In years last birthday)

67

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?  
U. S.

13. FATHER'S NAME

Charles Hopewell Hepburn

14. MOTHER'S MAIDEN NAME

Laura Wilmer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Florence Wilmer Hepburn 128 W. 24th St.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

Immediate  
Indefinite

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Atherosclerosis + Generalized Atherosclerosis

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Jan 1949 to Oct 17 1950 that I last saw the deceased alive on Oct 17, 1950 and that death occurred at 12:05 P.M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

St. Paul &amp; 23rd Sts.

23C. DATE SIGNED

10 - 18 - 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 19, 1950

24C. NAME OF CEMETERY OR CREMATORY

Hopewell

24D. LOCATION (City, town, or county) (State)

Port de Posit, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

John O. Mitchell &amp; Sons, Inc. - 1900 Eutaw Place

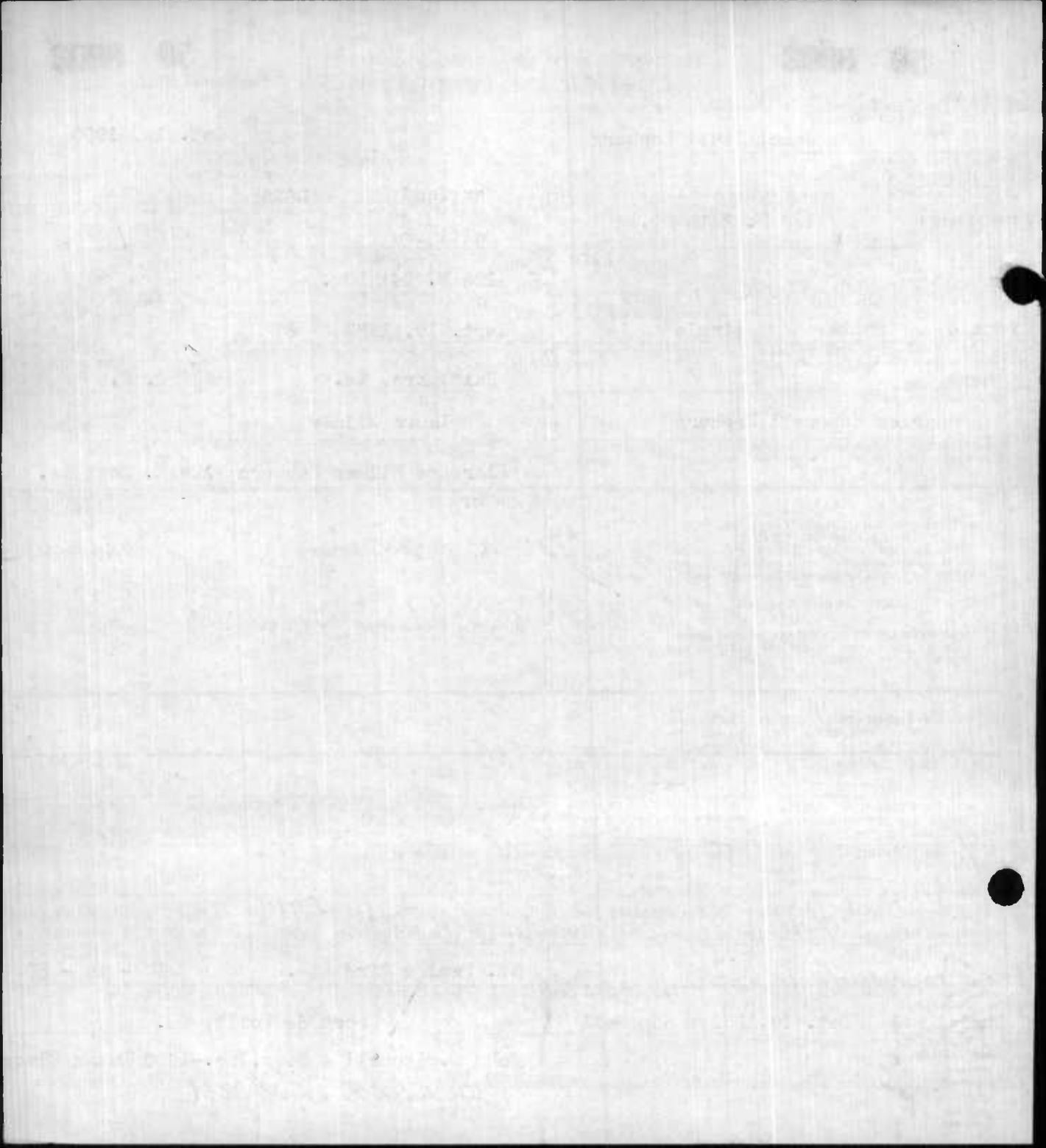
OCT 18 1950

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Wahlon B Mitchell

94a

MEDICAL CERTIFICATION



50 8903

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8903

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HOPE, CATHERINE

2. DATE  
OF  
DEATH

10-17-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore Md

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

University Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Glen Burnie

5200

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

58

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

Nov. 12, 1889

9. AGE (In years  
last birthday)

60 58

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

JANDERS.

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

GEORGE H. HOPE - SEVERNA PARK P.O.

18. 260x

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Diabetes Mellitus

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Arteriosclerosis CVD

DUE TO

(C)

Coronary failure

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐ NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from Oct 1, 1950 to Oct 17, 1950, that I last saw the  
deceased alive on Oct 17, 1950 and that death occurred at 1:00 A.M., from the causes and on the date stated above.

23A. SIGNATURE

H. J. J. J. J.

M. D.

23B. ADDRESS

University Loop

23C. DATE SIGNED

10-17-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

10/19/50

24C. NAME OF CEMETERY OR CREMATORY

GLEN HAVEN

24D. LOCATION (City, town, or county)

RITCHIE HIGHWAY

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

W. J. J. J. J.

25. FUNERAL DIRECTOR

ADDRESS

JOHN F. DENNY, INC 715 LIGHT ST.

OCT 18 1950  
VS 150

061.0

MEDICAL CERTIFICATION

correct age is especially important. Physicians: please write the causes of death clearly.





250 50 8904

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8904  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William H. Jackson

2. DATE  
OF  
DEATH

Oct. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

2408 Brentwood Ave.

Yrs.  
Mos.  
Days

Length of stay in Baltimore

SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 2, 1870

9. AGE (in years  
last birthday)

80

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Paperhanger

10B. KIND OF BUSINESS OR  
INDUSTRY

Skilled labor

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Andrew Jackson

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Estelle Jackson 2408 Brentwood Ave.

18. 431X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO

Acute Myocarditis

INTERVAL BETWEEN  
ONSET AND DEATH

5 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) DUE TO  
(C)II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 12, 1950 to Oct 17, 1950, that I last saw the  
deceased alive on Oct 17, 1950, and that death occurred on 3 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1088 05

1088 02

COPIES  
ASSETS

65 50 8905

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8905  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SUSIE J. BRANCH

2. DATE  
OF  
DEATH

16 Oct 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTIONGood Samaritan Hosp  
27 N. Carey St4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 13-03D. STREET ADDRESS (If rural, give location)  
2338 N. Cullough St.

Length of stay in Baltimore

6 DYS.

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

April 9, 1883

9. AGE (In years  
last birthday)

67

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

James Johnson

14. MOTHER'S MAIDEN NAME

Harriett Banks

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Doreatha Robinson 909 Baitlow St.

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebral hemorrhage and thrombosis

DUE TO Hypertensive and arteriosclerotic  
cardio-vascular disease

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10 Oct, 1950, to 16 Oct, 1950, that I last saw the  
deceased alive on 10 Oct, 1950, and that death occurred at 1:40 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Emil H. Hennings Jr.

M. D.

23B. ADDRESS

601 Winans Way

23C. DATE SIGNED

17 Oct 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 19, 1950

24C. NAME OF CEMETERY OR CREMATORY

Int. Calvary

24D. LOCATION (City, town, or county)

Baltimore Co. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

1601 David Hill Ave.

ADDRESS

Home

2003

20

2003

20

CHRYSLER CREDIT CORPORATION

50 8906

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8906

Registered No.

BIRTH NO. 48-19327

1. NAME OF DECEASED (Type or Print) <b>DAVID</b>		PATTON		2. DATE OF DEATH <b>October 15, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>South Baltimore General Hosp.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>11-64</b>			
D. STREET ADDRESS (If rural, give location) <b>1035 Tiffany Court</b>		E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>June 21, 1948</b>	9. AGE (In years last birthday) <b>2</b>	If Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>David Patton Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Rosa Fallin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>m.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Rosa Patton</b>	
18. ADDRESS <b>1035 Tiffany Ct.</b>					

18. E816.4

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) **Fracture of skull**

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Avulsion of left ear**

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Highway</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Gov. Ritchie H'way &amp; Walton Avenue</b>
21D. TIME (Month) (Day) (Year) (Hour) <b>October 15, 1950 10:02P m.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Passenger in auto and auto collision</b>

22. I certify that I took charge of the remains described above, held an **Insp. & Inquiry** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>William Bond</b>	23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....	23C. DATE SIGNED <b>10-16-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Oct. 16, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St. Peters</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	25. FUNERAL DIRECTOR <b>General Funeral Home</b>	ADDRESS <b>1631 Arundel Hill Ave.</b>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	

VS 151

N 803.2

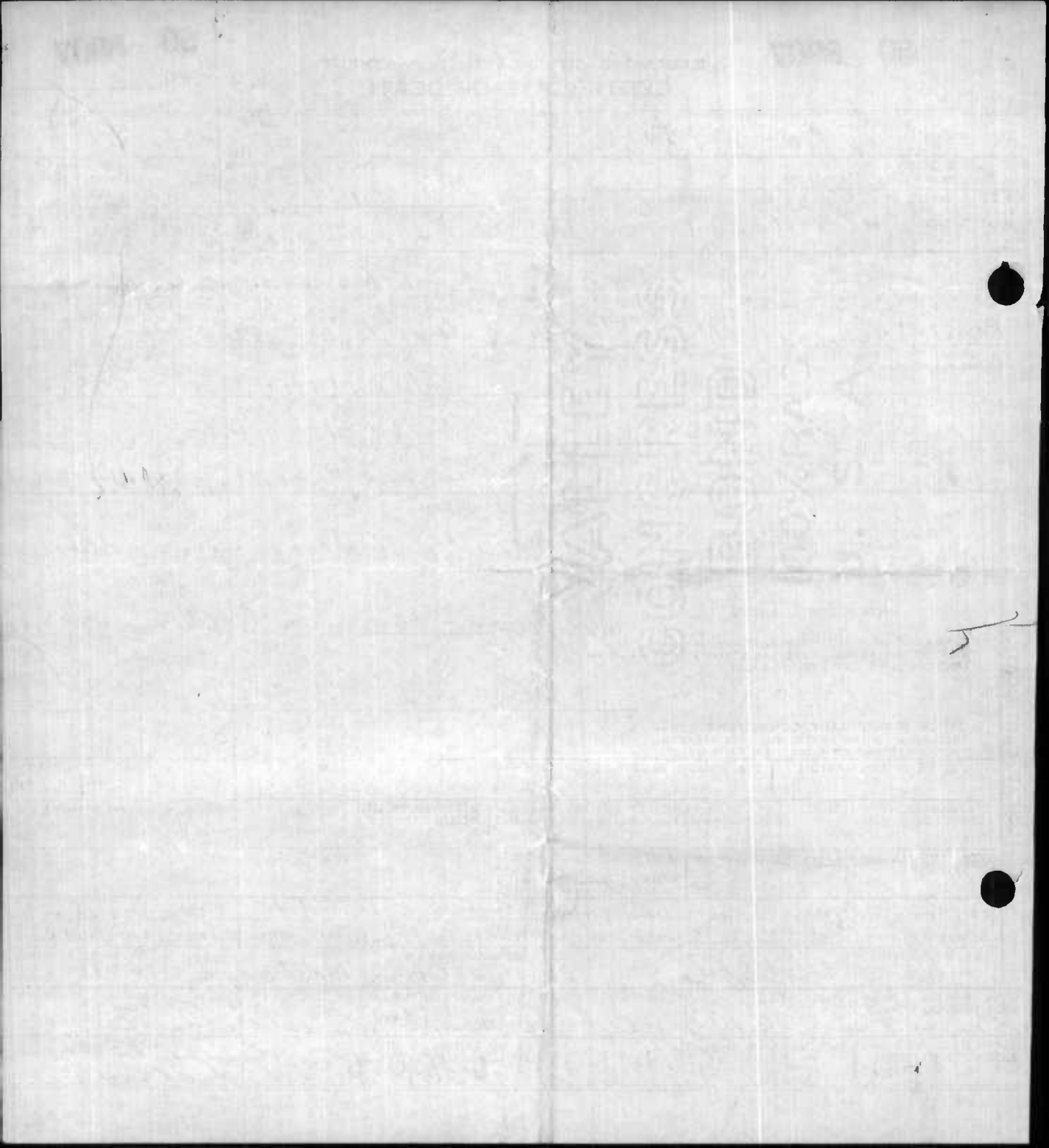
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MEDICAL CERTIFICATION









43250 8908

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8908

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas Fletcher

2. DATE  
OF  
DEATH

10/16/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

28 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

5309 Gwynn Oak Ave.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

Jan. 17, 1889

9. AGE (in years  
last birthday)

61

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Civil Engineer

10B. KIND OF BUSINESS OR  
INDUSTRY

Road Building

13. FATHER'S NAME

Joseph Fletcher

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Hannah Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.  
213-05-9892

17. INFORMANT

ADDRESS

Ave.

Mrs. Blanche L. Fletcher 5309 Gwynn Oak

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

(A) Myocardial Infarction

10 hrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) Coronary Occlusion

(C) Arteriosclerosis

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 10/16, 1950, to 10/16, 1950, that I last saw the  
deceased alive on 10/16, 1950, and that death occurred at 3:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

E. J. Hoyt

M. D.

23B. ADDRESS

Univ. Hosp.

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

10/19/50

24C. NAME OF CEMETERY OR CREMATORY

Spesutia Cem.

24D. LOCATION (City, town, or county)

Perryman, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams

25. FUNERAL DIRECTOR

Thos. J. Lichten &amp; Sons - Balt. Md.

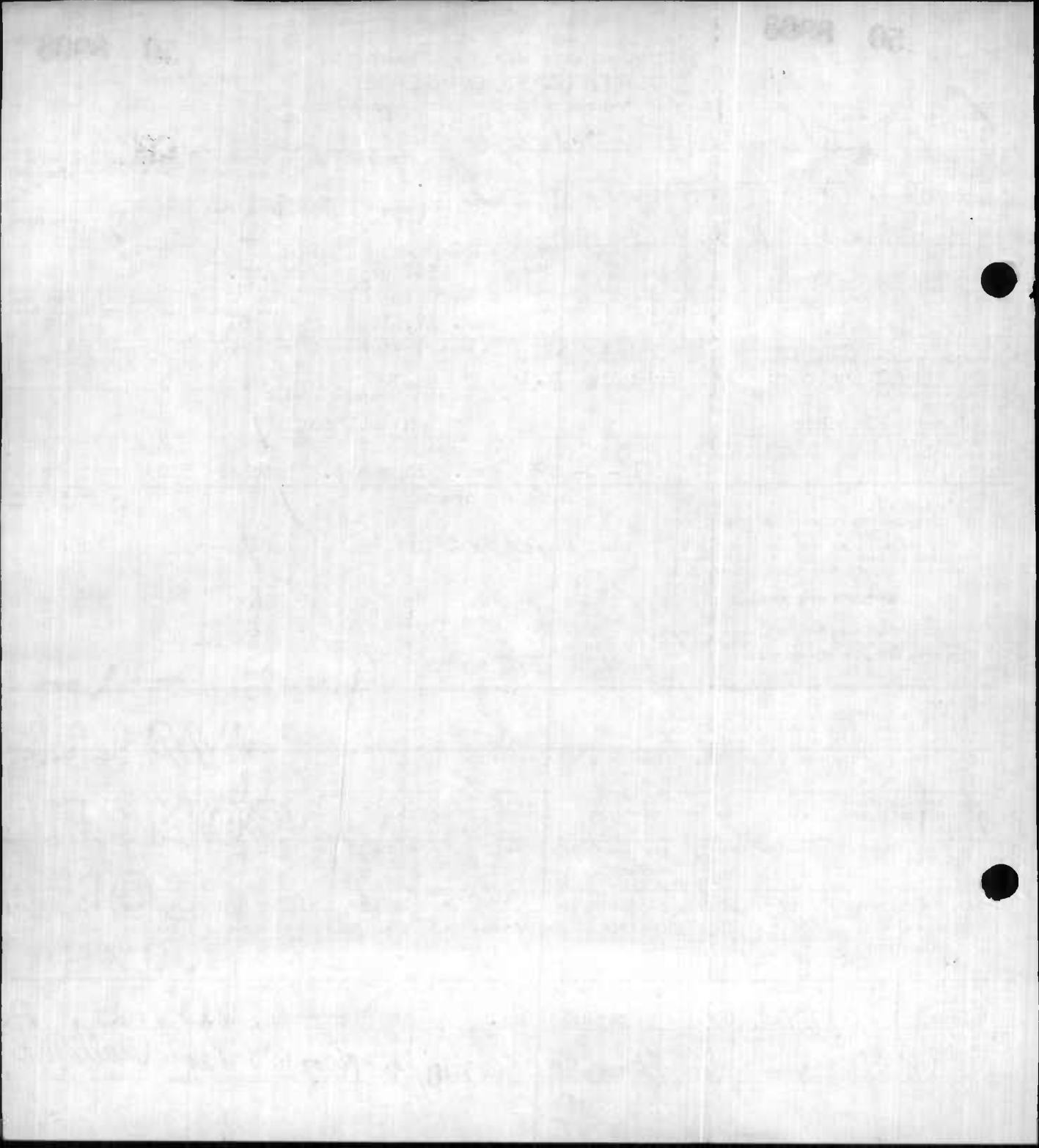
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094a

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

LAURA P. MORGAN

2. DATE  
OF  
DEATH

Oct. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

2915 The Alameda

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2915 The Alameda

Length of stay in Baltimore

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Feb. 17, 1876

9. AGE (In years last birthday)

74

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

-

12. CITIZEN OF WHAT COUNTRY?

-

13. FATHER'S NAME

Jeremiah Jackson

14. MOTHER'S MAIDEN NAME

Elizabeth Bruce

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

ADDRESS

Mrs. William Royer - 2915 The Alameda

18. 420.1  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Coronary Occlusion

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis & Hypertension

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN ONSET AND DEATH

2-

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 9-8 1950 to 10-17, 1950, that I last saw the deceased alive on 10-17, 1950, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

5407 Belair Rd.

10-17-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

10/20/50

Balto. Cem.

Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

10/18/1950

Wm. J. Scherer & Sons - Balto. Md.

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COPY 06

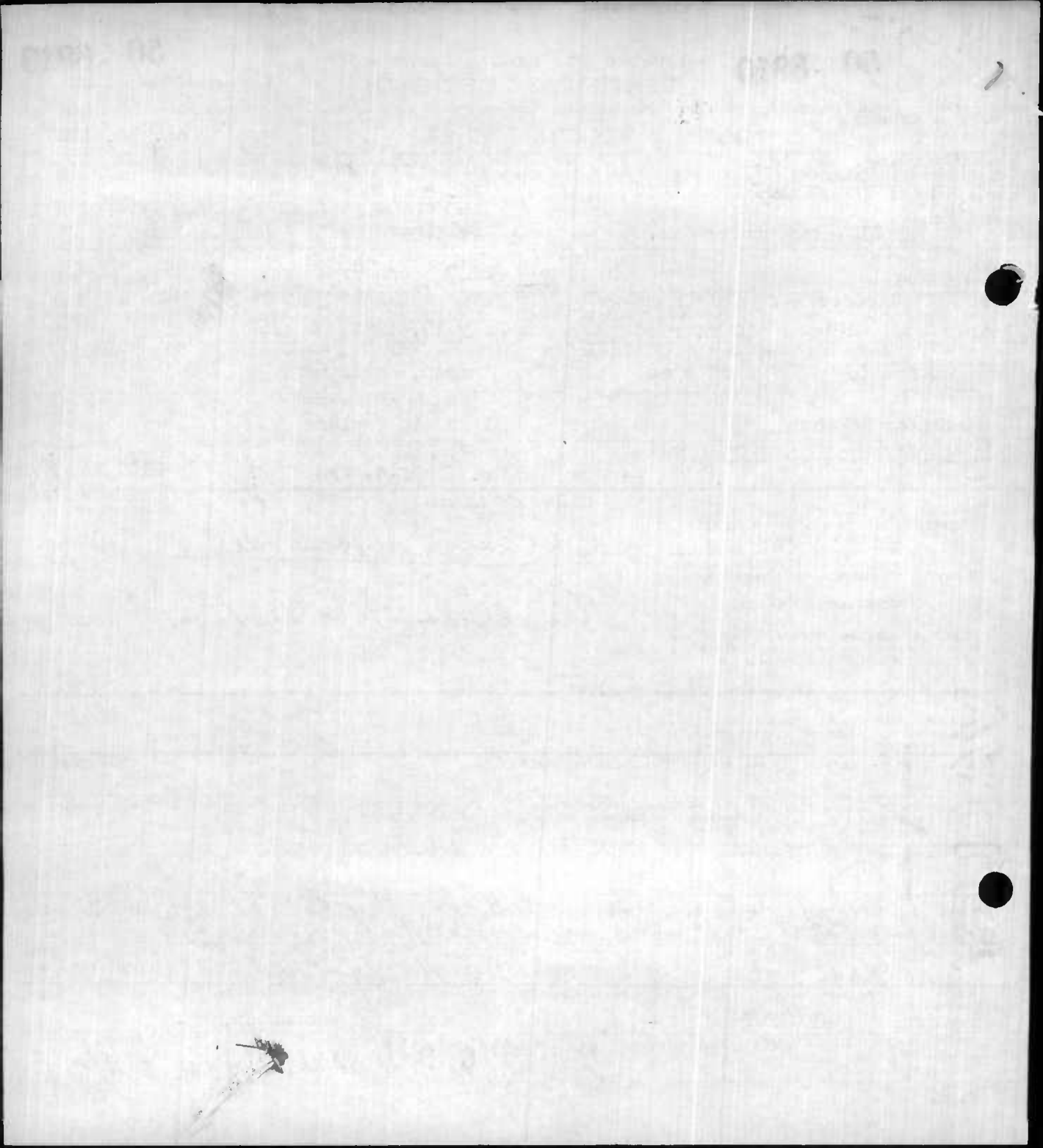
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# MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8911

1. PLACE OF DEATH:

(a) Baltimore City, Maryland  
(b) Street address 415 Mott  
(c) Hospital or institution: MOTT ST.  
(d) Length of stay in hospital or inst. (yrs., mos., or days)  
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County  
(c) City or town Balto 5-02  
(If outside city or town limits, write RURAL and give town)  
(d) Street No. 415 Mott  
(If rural give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3 (a) FULL NAME David Adkins

3 (b) If veteran, name war 3 (c) Social Security Account No. 213-03-0369

4. Sex M 5. Color or race B 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife. Lottie 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21st 1877

8. AGE: Years 73 Months 4 Days 2.5 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business ODD JOBS

12. Name Joseph Adkins

13. Birthplace Va.

14. Maiden Name Rebecca Nell

15. Birthplace Va.

16 (a) Informant Hattie E. Gray

(b) Address 415 Mott St

(a) Burial (b) Date thereof Oct. 18 1950

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co. Md

18 (a) Funeral director Mamie W. Wright

(b) Address 721 Asquith St

19 (a) OCT 18 1950 (b) (Date rec'd by registrar) Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15 1950, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8 1950, to 10/15 1950, and that I last saw him alive on 10/14 1950

Immediate cause of death

Cerebral Hemorrhage

Due to Hypertension

Due to Arterio-sclerosis

Other Conditions Hemiplegia

Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Ralph E. Young M. D.

Address 124 E Monument St Date signed 10/16/50

DURATION

1 wk

3 yrs

3 yrs

1 wk

PHYSICIAN

Underline the cause to which death should be charged statistically.

Underline the cause to which death should be charged statistically.

Underline the cause to which death should be charged statistically.

Underline the cause to which death should be charged statistically.

Underline the cause to which death should be charged statistically.

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Underline the cause to which death should be charged statistically.

Underline the cause to which death should be charged statistically.

Underline the cause to which death should be charged statistically.

## INSTRUCTIONS FOR MEDICAL CERTIFICATION

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### WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

### DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

### DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

### DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

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For additional discussion of this subject see **PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION** issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

**50 8912**  
G-100  
BIRTH NO.

**50 8912**  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>William</b>		2. DATE OF DEATH <b>Oct. 16, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 23-01</b>	
D. STREET ADDRESS (If rural, give location) <b>133 W. Cross St.</b>		E. LENGTH OF STAY IN BALTIMORE <b>20 yrs</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>62 yrs</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labour</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Paint Factory</b>	9. AGE (In years last birthday) <b>62 yrs</b>
13. FATHER'S NAME <b>Richard Cuba</b>		11. BIRTHPLACE (State or foreign country) <b>A. A. Co. Ind</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Lottie's Birth</b>	
17. INFORMANT <b>Cora Hammond, Sever, Ind</b>		ADDRESS	

**CAUSE OF DEATH**

18. <b>451x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>(A) Rupture of dissecting aneurysm of aorta into pericardial sack</b> DUE TO  <b>(B)</b> DUE TO  <b>(C)</b> ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH
--	----------------------------------

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>Stanley S. Quinlan</b>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>Oct. 17, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Oct 19</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St. Rest. Am.</b>	24D. LOCATION (City, town, or county) (State) <b>A. A. Co Ind</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 18 1950</b>		REGISTRAR'S SIGNATURE <b>William W. Williams</b>		25. FUNERAL DIRECTOR <b>James A. Hayes</b>	

NO 8043

NO 8043

RECEIVED

RECEIVED

NO 8043

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NO 8043



H-6-52 8913

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8913

BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

RICHARD HERRING, JR.

## 2. DATE

OF

DEATH October 16, 1950

## 3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Johns Hopkins Hospital

## 4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

## C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Baltimore

## D. STREET ADDRESS (If rural, give location)

1114 E. Pratt Street

## 5. SEX

male

## 6. COLOR OR RACE

colored

## 7. SINGLE, MARRIED

WIDOWED, DIVORCED (Specify)

Separated

## 8. DATE OF BIRTH

1-29-1921

## 9. AGE (In years

last birthday)

29

## If Under 1 Year

Months: Days

## If Under 24 Hours

Hours: Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

## 10B. KIND OF BUSINESS OR INDUSTRY

Construction

## 11. BIRTHPLACE (State or foreign country)

Manning, S. C.

## 12. CITIZEN OF WHAT COUNTRY?

U. S. C.

## 13. FATHER'S NAME

Richard Herring Sr.

## 14. MOTHER'S MAIDEN NAME

Marie Sowers

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes; no or unknown)

no

(If yes, give war or dates of service)

no

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

Marie Herring-

Secretary,  
S. C.

18. 353.3

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Epilepsy

DUE TO

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

## 19A. DATE OF OPERATION

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

## 23A. SIGNATURE

William Herring

## 23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

M.D.

MEDICAL INVESTIGATOR.....

## 23C. DATE SIGNED

Oct. 16, 1950

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Shipped

## 24B. DATE

10-20-50

## 24C. NAME OF CEMETERY OR CREMATORY

Sumter, S. C.

## 24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

OCT 18 1950

## REGISTRAR'S SIGNATURE

William Herring

## 25. FUNERAL DIRECTOR

800 E. Halstead - 918 - ✓

## ADDRESS

David Hill Ave.

50 R413

STATE OF NEW YORK

50 R413

50 R413

C-534  
50 8914BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8914  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Bessie Chandler

2. DATE  
OF  
DEATH

OCT 17 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Cal 4

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

15-01

D. STREET ADDRESS (If rural, give location)

1707 N. Mount St.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

8. DATE OF BIRTH

9. AGE (in years  
last birthday)If Under 1 Year  
Months: Days Hours: Min.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 260X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Myocardial Infarction

3 weeks

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Coronary sclerosis  
(C) Diabetes mellitus

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 9-28-1950 to 10-17-1950 that I last saw the  
deceased alive on 10-17-1950 and that death occurred at 3:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

JOHNS HOPKINS HOSPITAL

Oct 17 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

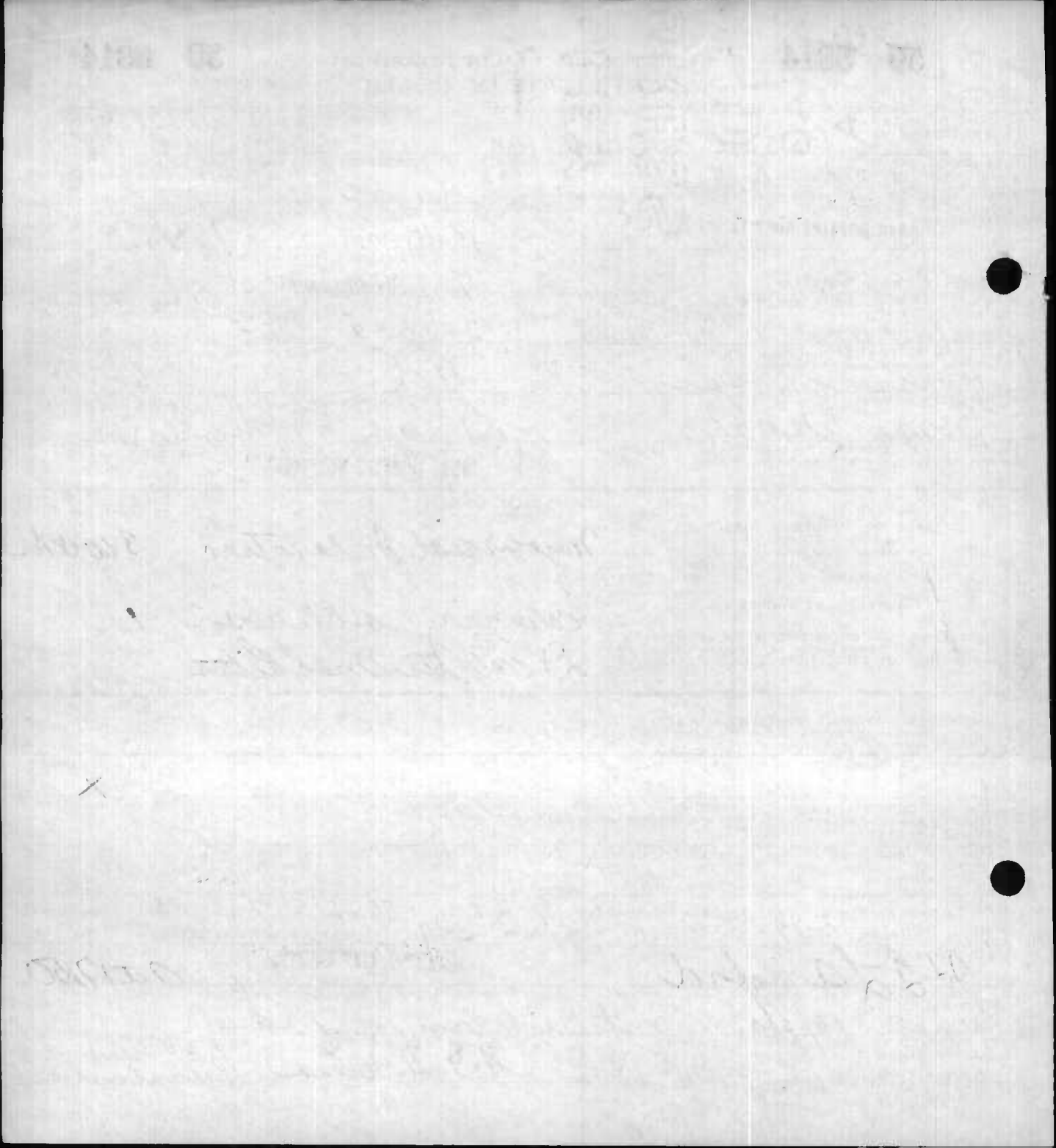
ADDRESS

OCT 18 1950

Washington, D. C.

H. Nelson Prestman Jr.

061.0



J-502 8915

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8915  
Registered No.

BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

CHAS. HENRY JONES

## 2. DATE

OF

DEATH

October 13, 1950

## 3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Franklin Square Hospital

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2211 Clifton Avenue

Length of stay in Baltimore

SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

1877

9. AGE (In years last birthday)

73

10. Under 1 Year  
Months Days  
11. Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR INDUSTRY

none at present

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

unobtainable

14. MOTHER'S MAIDEN NAME

unobtainable

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

ADDRESS

Mary C. Taylor 544 Gold St.

18. 443X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anteriosclerotic/cardiovascular disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

2. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....☐

23C. DATE SIGNED

ASSISTANT MEDICAL EXAMINER.....☒

October 14, 1950

MEDICAL INVESTIGATOR.....☐

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

10/21/50

Chatham

Chatham, Virginia

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Geo. G. Kelson 1303 Presstman St.

VS 151

82010

093d





W-320  
50 8916BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8916  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Walter Watts

2. DATE  
OF  
DEATH

10/16/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Provident Hospital

Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

3

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

15-01

D. STREET ADDRESS (If rural, give location)

1310 Stoclet Street

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

More HODGKINSON HOME ST

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Charles Watts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Doris Harrison

ADDRESS

1310 Stoclet St

18. 42010

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Uremia

Sept 7-1950

DUE TO

Hypertensive + arteriosclerotic heart disease

(B)

Uremia

October 16, 1950

DUE TO

Chronic glomerulonephritis

(C)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 15, 1950, to October 16, 1950; that I last saw the deceased alive on October 16, 1950, and that death occurred at 7:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

A. Nicolas

M. D.

23B. ADDRESS

Provident Hospital

23C. DATE SIGNED

10/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

10/19/50

24C. NAME OF CEMETERY OR CREMATORY

St Peters

24D. LOCATION (City, town, or county)

Ind

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Geo. H. Nelson

303 Presumably

97024

131a

correct age is especially important. Physicians write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

27-10-1985

S-152  
50 8917BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8917  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES Sappington</b>		2. DATE OF DEATH <b>10-17-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore, Md</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Covington St.</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>FRANKLIN SQUARE Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>2402</b>	
D. STREET ADDRESS (If rural, give location) <b>1444 COVINGTON ST.</b>		Yrs. Mos. Days	
5. LENGTH OF STAY IN BALTIMORE <b>42 yrs.</b>		8. DATE OF BIRTH <b>7-29-1883</b>	
6. COLOR OR RACE <b>WHITE</b>		9. AGE (In years last birthday) <b>67</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		10. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary Engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Baker &amp; Fountain Supply Co. Md.</b>	
13. FATHER'S NAME <b>JAMES Sappington</b>		14. MOTHER'S MAIDEN NAME <b>MARY Woods</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>213-01-9624</b>	
17. INFORMANT <b>Mrs. James H. Sappington</b>		ADDRESS <b>1444 Covington St.</b>	
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>myocardial infarction</b> DUE TO <b>coronary artery thrombosis</b> DUE TO <b>coronary sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 days</b> <b>Not known</b>	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Oct 15</b> , 1950 to <b>Oct 17</b> , 1950, that I last saw the deceased alive on <b>Oct 16</b> , 1950, and that death occurred at <b>5:15 A.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Spencer A. Arnold</b>		23B. ADDRESS <b>Franklin Sq. App.</b>	
M. D.		23C. DATE SIGNED <b>Oct 17, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 20-1950</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie - Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR		25. FUNERAL DIRECTOR <b>Charles J. Schwab</b>	
REGISTRAR'S SIGNATURE		ADDRESS <b>3512 Frederick, Aoe.</b>	

MEDICAL CERTIFICATION

OCT 18 1950

58363

094a

1938

62

RECEIVED  
JAN 10 1938

1938

C-500  
50 8918BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8918

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>TILUE COHEN</b>		2. DATE OF DEATH <b>10-18-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Leunclab Aged Home</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 27-16</b>	
Length of stay in Baltimore <b>30 YRS.</b>		D. STREET ADDRESS (If rural, give location) <b>4725 Park Heights Ave</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>1881</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	9. AGE in years last birthday <b>68</b>
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Morris Winokoen</b>		14. MOTHER'S MAIDEN NAME <b>Baala?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. INFORMANT ADDRESS <b>Mrs. Sarah Jacobs - 4725 Park Heights Ave</b>	
16. SOCIAL SECURITY NO.			

18. <b>422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Chronic cardiovascular disease</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	CAUSE OF DEATH <b>Chronic cardiovascular disease</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>diabetes mellitus</b> DUE TO <b>years</b>	

19A. DATE OF OPERATION <b>10-18-50</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

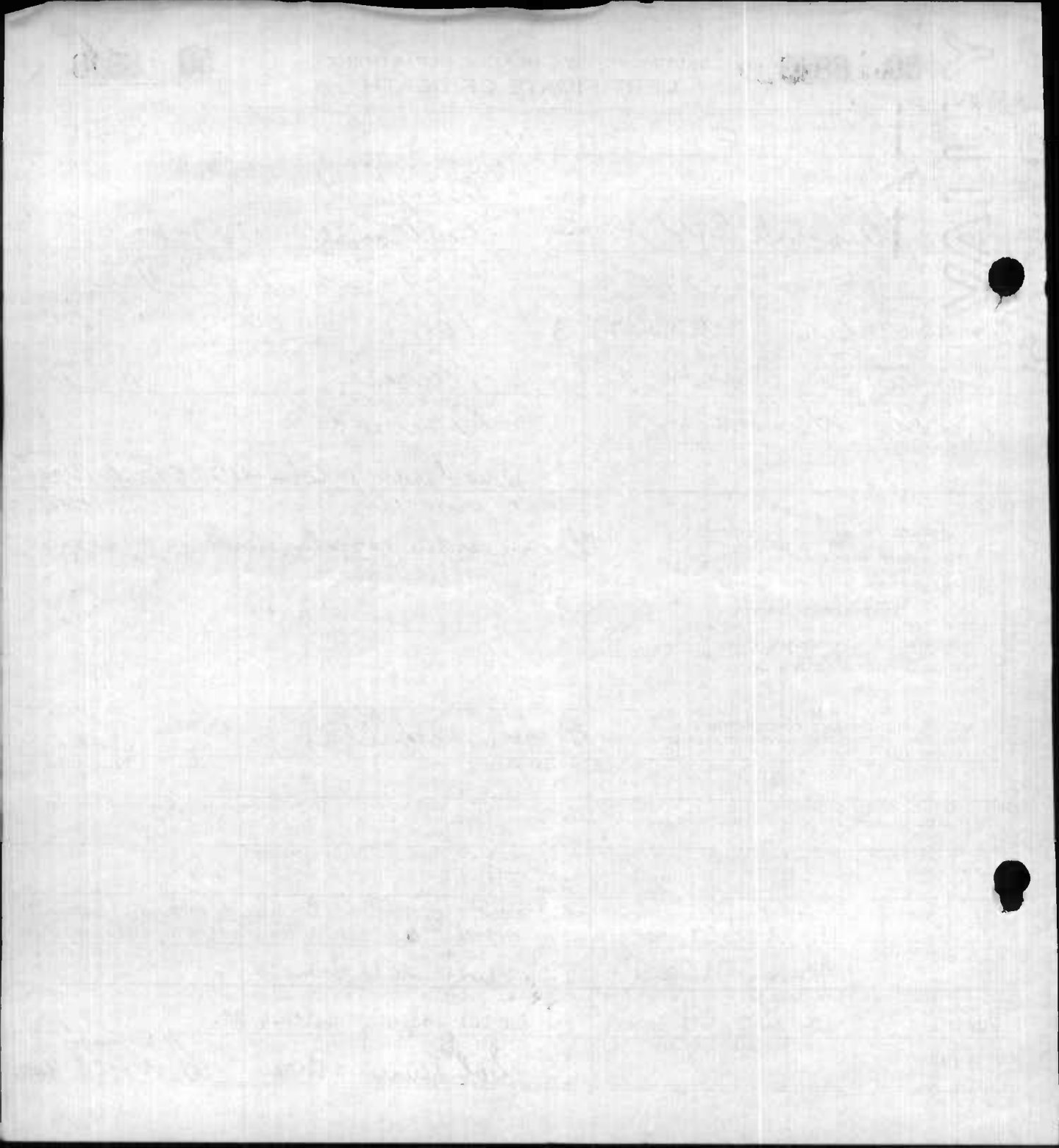
22. I hereby certify that I attended the deceased from **9-25**, 19**50**, to **10-18**, 19**50**, that I last saw the deceased alive on **10-18**, 19**50**, and that death occurred at **12:45** a. m., from the causes and on the date stated above.

23A. SIGNATURE <b>Harry Nagel</b>	23B. ADDRESS <b>Leunclab Home</b>	23C. DATE SIGNED <b>10-18-50</b>
--------------------------------------	--------------------------------------	-------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-19-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Hebrew Free Burial Society, Balto., Md.</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 18 1950</b>	REGISTRAR'S SIGNATURE <b>W. North</b>	25. FUNERAL DIRECTOR <b>Sol. Levinson &amp; Bros. 1124 26 W. North Ave</b>	

VS 150

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2017

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

100-100000

[Faint, illegible text throughout the page, likely bleed-through from the reverse side. The text is mirrored and difficult to decipher.]

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8920  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Delia Ingham		2. DATE OF DEATH Oct 18 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION 1008 Augusta avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 16-08	
Length of stay in Baltimore 2 yrs		D. STREET ADDRESS (If rural, give location) 1008 Augusta Ave.	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH Nov 4 1879
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years - last birthday) 70
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Ingham		14. MOTHER'S MAIDEN NAME Elizabeth *****	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Lawrence Connolly		ADDRESS 1008 Augusta ave.	

18. 420.0

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Anteriosclerotic heart disease

10 months

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4/29, 1949, to 10/18, 1950, that I last saw the deceased alive on 10/18, 1950, and that death occurred at 9:45 a. m., from the causes and on the date stated above.					
23A. SIGNATURE Robert A. Reiter		23B. ADDRESS M. D. 3408 Windsor Ave.		23C. DATE SIGNED 10/18/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct 21 1950		24C. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.	
		24D. LOCATION (City, town, or county) Amsterdam New York		(State)	
DATE RECEIVED BY LOCAL REGISTRAR 18/1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR 8 Charles H. [Signature] 118 W. Mt. Royal Ave. 093d	

1000 00

1000 00



6-530  
50 8921BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8921

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EMMA

COMOTTO

2. DATE OF DEATH  
October 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE  
Johns Hopkins Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BaltimoreD. STREET ADDRESS (If rural, give location)  
25 S. Potomac St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

Sept. 10, 1897

9. AGE (In years last birthday)

53

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Housewife10B. KIND OF BUSINESS OR INDUSTRY  
-----11. BIRTHPLACE (State or foreign country)  
Italy

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
John Venchio14. MOTHER'S MAIDEN NAME  
Mary ?15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
-----16. SOCIAL SECURITY NO.  
-----17. INFORMANT  
Marcel ComottoADDRESS  
25 S. Potomac St.

18. E976.X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet wound of head

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  
Home21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
25 S. Potomac St.

21D. TIME (Month) (Day) (Year) (Hour)

Oct. 16, 1950

?

Pm.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒21F. HOW DID INJURY OCCUR?  
Firearms22. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐.23A. SIGNATURE  
Stanley H. Quilacher

M.D.

23b. CHIEF MEDICAL EXAMINER.....☐  
ASSISTANT MEDICAL EXAMINER.....☒  
MEDICAL INVESTIGATOR.....☐23c. DATE SIGNED  
Oct. 17, 195024A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial24b. DATE  
10/20/5024c. NAME OF CEMETERY OR CREMATORY  
Holy Redeemer Cem24d. LOCATION (City, town, or county) (State)  
Baltimore Md.DATE RECEIVED BY LOCAL REGISTRAR  
OCT 18 1950REGISTRAR'S SIGNATURE  
Thurston Williams25. FUNERAL DIRECTOR  
John A. MoranADDRESS  
3000 E. Balto. St.

1928 02

1928 02



324  
REA-142504

50 8922

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8922  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Beatrice Ratcliffe		2. DATE OF DEATH October 18, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-15	
c. Length of stay in Baltimore 2 years		D. STREET ADDRESS (If rural, give location) 2213 Enslow Avenue	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 20, 1907
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 42
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Cyrus Bomberger		14. MOTHER'S MAIDEN NAME Florence Morley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records: B. C. H.		ADDRESS 4940 Eastern Avenue	

18. 490X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Pneumonia both lungs  
DUE TO Staphylococcus

1 Week

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)  
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10-13, 1950, to 10-18, 1950, that I last saw the deceased alive on 10-18, 1950, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

4940 Eastern Avenue

10-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 18 1950

VS 150

Huntington Williams, M.D.

John D. Mitchell & Sons  
1900 Eutan Pk.  
1080

SSSB 02

SSSB 02







correct age is especially important. Physicians: please write the causes of death clearly and legibly.

241

50 8924

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8924  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM

MC CALEB

2. DATE  
OF  
DEATH

October 12, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
FRANKLIN SQUARE HOSPITAL

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Dec. 17, 1887

9. AGE (in years  
last birthday)

62 63

10 Under 1 Year  
Months: Days

11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
Construction

10B. KIND OF BUSINESS OR  
INDUSTRY  
LABORER

11. BIRTHPLACE (State or foreign country)

Iron Hill, Tenn.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Albert McCaleb

14. MOTHER'S MAIDEN NAME

Bethie Haile

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

William Upton, 410 N. Carey Street

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., In or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

M.D.

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

October 13, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1988

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BALTIMORE CENTER FOR HEALTH RESEARCH  
CENTRE OF HEALTH

1988

50





530 50 8925

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8925  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Minnie Schnuit

2. DATE  
OF  
DEATH

Oct 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto Md

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

1316 E. Fort Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Balto

24-01

D. STREET ADDRESS (If rural, give location)

1316 E. Fort Ave.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

widowed

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

unknown

8. DATE OF BIRTH

6-2-1875

9. AGE (in years  
last birthday)

75

11 Under 1 Year  
Months: Days

4 14

11. BIRTHPLACE (State or foreign country)

Bassum, Germany

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Minnie Pickert

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

John Schnuit 1316 E. Fort Ave

18. 260X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Coronary thrombosis  
DUE TO

1 day

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Arteriosclerosis  
DUE TO

5 yr.

(C) Diabetes Mellitus  
DUE TO

5 yr.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 10, 1948, to 10-15, 1950, that I last saw the  
deceased alive on 10-15, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

A. Sollo

23B. ADDRESS

707 E. Fort Ave.

23C. DATE SIGNED

10-17-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

10-19-50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn Cem.

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. H. Williams, M.D.

25. FUNERAL DIRECTOR

8 Has. 2/Will

ADDRESS

1501 E. Fort Ave.

OCT 18 1950

VS 150

061.0

MEDICAL CERTIFICATION

20-8082

20-8082



correct age is especially important. Physicians: please write the causes of death clearly and legibly.

<div style="display: flex; justify-content: space-between;"> <span>520</span> <span>50 8926</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>X 50 8926</span> </div> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>		Registered No. _____	
BIRTH NO. _____					
1. NAME OF DECEASED (Type or Print) <b>LEON JOSEPH JONES</b>				2. DATE OF DEATH <b>Oct. 18, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>US Marine Hospital</b> <b>Hyman Pk. Drive &amp; 31st St.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>D.C.</b> <span style="margin-left: 20px;">B. COUNTY <b>V-48</b></span> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Washington</b> D. STREET ADDRESS (If rural, give location) <b>1030 Fairmont Street, NW</b>		
c. Length of stay in Baltimore <b>56 days</b>			Yrs. <b>0</b> Mos. <b>0</b> Days <b>0</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>col</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>7/20/25</b>	9. AGE (In years last birthday) <b>25</b>	If Under 1 Year Months: <b>0</b> Days: <b>0</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oiler</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Seafarer</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Joseph Jones</b>			14. MOTHER'S MAIDEN NAME <b>Maggie Forney</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>yes- # ?</b>		17. INFORMANT ADDRESS <b>Records- US Marine Hospital, Balto, Md.</b>	
<b>18. 178X I CAUSE OF DEATH</b>					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Teratoma of right testes with metastases to periaortic and mesenteric lymph nodes.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Pulmonary edema, slight.</b>				<b>Hours</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>✓</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Aug. 23, 1950</b> to <b>Oct. 18, 1950</b> , that I last saw the deceased alive on <b>Oct. 18, 1950</b> , and that death occurred at <b>10:50 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>John L. Wilson, Medical Director</b>		23B. ADDRESS <b>US Marine Hospital, Balto, Md.</b>		23C. DATE SIGNED <b>10/18/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>10.23.50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Washington, D.C.</b>	
24D. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Robert E. McLevin 1820 9th N.W. Wash. D.C. 051C</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 18 1950</b>		REGISTRAR'S SIGNATURE <b>Antington Williams, Md</b>		662 55	

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death	
9. Signature of Registrar		10. Signature of Medical Officer		11. Signature of Coroner		12. Signature of Police Officer	
13. Date of Burial		14. Place of Burial		15. Name of Burial Place		16. Name of Minister of Religion	
17. Name of Informant		18. Address of Informant		19. Signature of Informant		20. Date of Statement	

50 8927

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8927

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lillie May Carlisle

2. DATE  
OF  
DEATH

10-17-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

834 William St.

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

834 William St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

MAY 29, 1866

9. AGE (In years  
last birthday)

84

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Carlisle

14. MOTHER'S MAIDEN NAME

Elizabeth Meredith

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Joseph Carlisle 834 William St.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TO

Terminal Bronchopneumonia

15 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO

Generalized atherosclerosis

10 yr.

(C) .....  
DUE TO

Hypertension C. V. Disease

20 yr +

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-12-48, 19 to 10-17-50, 19, that I last saw the  
deceased alive on 10-17-50, 19, and that death occurred at 4:55 P.M. from the causes and on the date stated above.

23A. SIGNATURE

J. D. Dingle M.D.

23B. ADDRESS

642 N. W. D. D.

23C. DATE SIGNED

10-18-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

10-21-50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Frederick Rd. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

J. D. Dingle

25. FUNERAL DIRECTOR

ADDRESS

JOHN F. DENNY, INC 715 LIGHT ST.

VS 150

093 d

correct age is especially important. Physicians: please write the cause or cause of death clearly and legibly.

MEDICAL CERTIFICATION

1917-18  
The following is a list of the names of the persons who have been  
admitted to the membership of the Society since the last meeting.  
The names are given in alphabetical order of the surnames.  
The names of the persons who have been admitted to the membership  
of the Society since the last meeting are given in alphabetical order  
of the surnames.



50 8928

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8928  
Registered No.

BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

MAMIE HARRISON

## 2. DATE

OF

DEATH September 4, 1950

## 3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Baltimore City Hospital

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

## 5. SEX

female

## 6. COLOR OR RACE

colored

## 7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

U

## B. DATE OF BIRTH

U

## 9. AGE (In years

last birthday)

80

If Under 1 Year

Months; Days

If Under 24 Hours

Hours; Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

K

11. BIRTHPLACE (State or foreign country)

K

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

N

14. MOTHER'S MAIDEN NAME

O

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

N

17. INFORMANT

N

ADDRESS

18. E802X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple fractures involving skull and other bones

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

railroad yard

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Pennsylvania R.R. yard at Bayview

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

September 4, 1950 8.35

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Accidentally run over by train

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. Lovett

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒

23C. DATE SIGNED

Sept. 5, 1950

M.D.

MEDICAL INVESTIGATOR.....☐

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 151

N 804.2

UNIVERSITY MEDICAL SCHOOL SEP 25 1950

Commissioner of Health

1690

850

50 8929

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8929

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM I. BROWN Jr.

2. DATE

OF

DEATH OCT. 16th, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md

5. FULL NAME OF (If not in hospital or institution, give street address or location)

2409 Montebello Terrace

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2409 Montebello Terrace

c. Length of stay in Baltimore 30yrs

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

6/9/1910

9. AGE (In years, last birthday)

40

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Automobile (R)

11. BIRTHPLACE (State or foreign country)

Calvert County, Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Wm. I. Brown Sr.

14. MOTHER'S MAIDEN NAME

Mary Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Eva Brown

ADDRESS

Mrs. Evany Brown (M) 2417 College Ave

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

54-25 hrs

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 06/15, 1953 to 06/16, 1950 that I last saw the deceased alive on 06/16, 1950, and that death occurred at 11:45 PM on the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE, SIGNED

M. D.

803 W. Fremont

10-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/19/50

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Mem'l. Pk.

24D. LOCATION (City, town, or county)

Balto. County, Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 19 1950

T. J. Williams, M.D.

Chas. Harper

512 N. Carrollton A

1938

1938

RECEIVED BY THE  
OFFICE OF THE  
TREASURER

For

1938

552  
50 8930BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8930  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Rose Theresa Timanus

2. DATE OF DEATH  
October 19 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION 1944 W. Lexington STREET4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE MARYLAND B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BALTIMORE 20-01D. STREET ADDRESS (If rural, give location)  
1944 W. Lexington ST.

c. Length of stay in Baltimore 70

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
WIDOWED8. DATE OF BIRTH  
March 19, 18809. AGE (In years last birthday)  
70

10. Under 1 Year Months: Days 10 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
House WIFE10B. KIND OF BUSINESS OR INDUSTRY  
Own home11. BIRTHPLACE (State or foreign country)  
MARYLAND12. CITIZEN OF WHAT COUNTRY?  
USA13. FATHER'S NAME  
Patrick Gillette14. MOTHER'S MAIDEN NAME  
Ida LYLE15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
NO16. SOCIAL SECURITY NO.  
NONE17. INFORMANT ADDRESS  
Mrs. Ruth Kregel, 1944 W. Lex ST.

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
DUE TO

(A) Auricular Fibrillation

19 months

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
DUE TO

(B) Hypertensive Cardiovascular Disease

20 years

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
(C) Diabetes Mellitus

1 month

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1950, to October 19, 1950, that I last saw the deceased alive on October 18, 1950, and that death occurred at 2:55 A. M., from the causes and on the date stated above.

23A. SIGNATURE  
Melvin W. Borden

M. D.

23B. ADDRESS  
2030 W. Fayette St23C. DATE SIGNED  
10/17/5024A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial24B. DATE  
10-21-5024C. NAME OF CEMETERY OR CREMATORY  
London Park24D. LOCATION (City, town, or county)  
Balto. Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR  
OCT 19 1950REGISTRAR'S SIGNATURE  
T. M. M. M. M.25. FUNERAL DIRECTOR  
Fred. E. Beyer Jr1512 Hollins St  
Balto 23 Md





200  
50 8931BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8931  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Jane L. Magee

2. DATE  
OF  
DEATH

Oct 15 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto Md.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

2813 Hudson St.

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

D. STREET ADDRESS (If rural, give location)

2813 Hudson St.

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Corsetiere (retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Simon Magee

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

212-10-8860

8. DATE OF BIRTH

June 24 1875

9. AGE (In years  
last birthday)

77

11 Under 1 Year  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Bridget Larkin

17. INFORMANT

ADDRESS

Mrs Margaret Quinn 2813 Hudson St.

18. 153X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Carcinoma Cecum (Inoperable)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 15, 1950, to Oct. 15, 1950, that I last saw the  
deceased alive on Oct 14, 1950, and that death occurred at 7:10 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Oct 19 1950

New Cathedral

Baltimore

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 19 1950

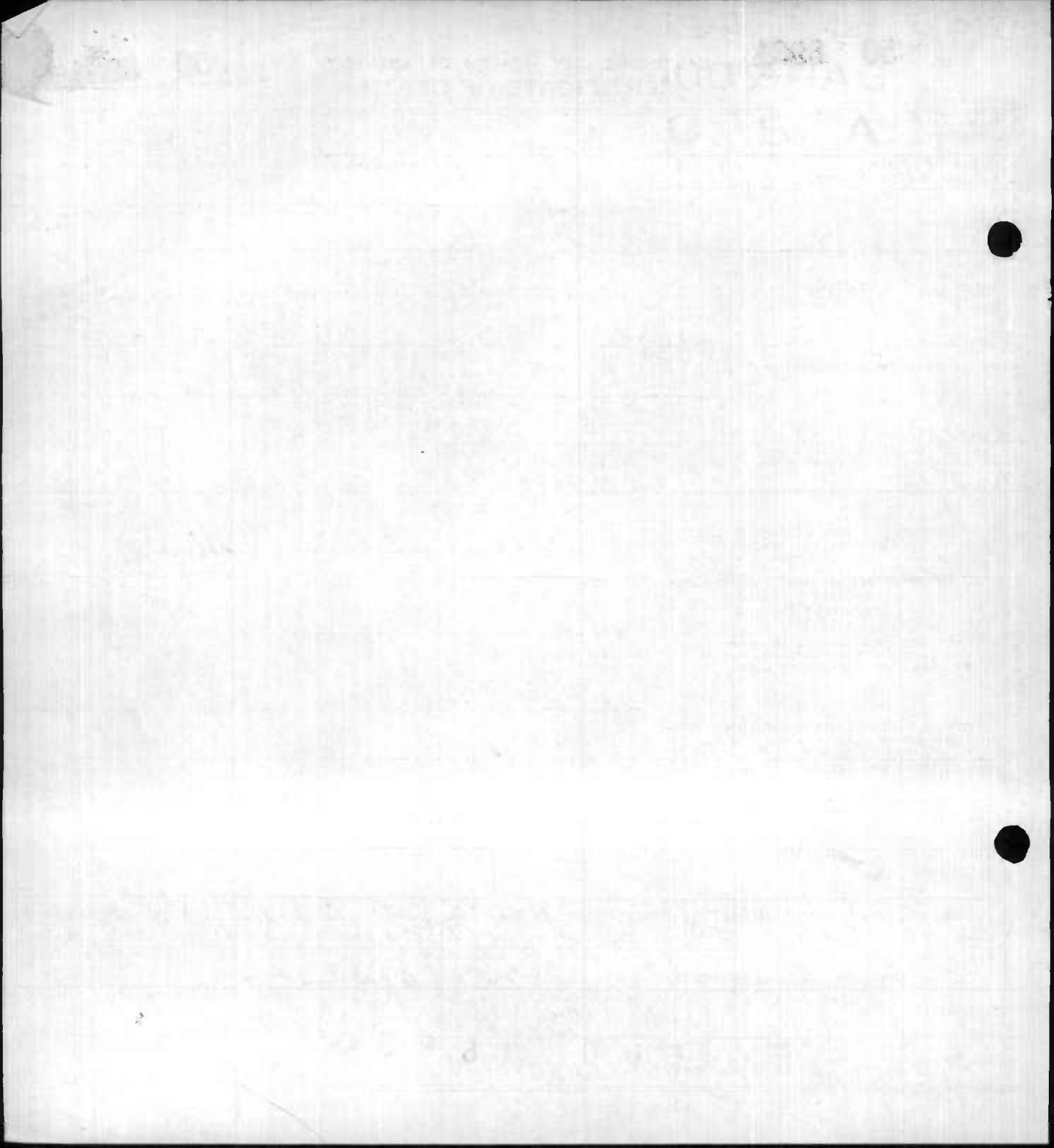
Thurston Williams, Jr.

John J. Ruda, Inc. 2829 Hudson

0462 St.

MEDICAL CERTIFICATION

correct age as especially important. Physicians, please write the cause of death clearly and legibly.



50 8932

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8932

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary E. Brown

2. DATE  
OF  
DEATH

Oct. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

13-03

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

1132 W. North Ave.

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL, and give township)

D. STREET ADDRESS (If rural, give location)

1132 W. North Ave.

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

March 11, 1874

9. AGE (In years  
last birthday)

76

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Harriet Preston

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS 1132 W.  
Mrs. Hattie B. Douglas North Ave.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Chronic myocarditis

4 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) arterio sclerosis

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/10/50 to 10/17/50, that I last saw the  
deceased alive on 10/16/50, and that death occurred at 6:30 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Dan J. Trautman M. D.

23B. ADDRESS

122 W. See

23C. DATE SIGNED

10/18/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

5-20-50

24C. NAME OF CEMETERY OR CREMATORY

Arlington Memorial

24D. LOCATION (City, town, or county)

Balto. Co.

(State)

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Mrs. Francis A. Hensley Bidder

ADDRESS

578 W.

5228

03

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DEPARTMENT OF THE ARMY

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8933

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8933

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Martha E. Hunter</b>			2. DATE OF DEATH <b>Oct. 17/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>1926 Orleans St.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>1926 Orleans St.</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto. Md. 6-04</b>		
c. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>1926 Orleans St.</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Dec. 27, 1863</b>	9. AGE (in years last birthday) <b>86</b>	H Under 1 Year Months: Days H Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <b>---Jordan</b>		
14. MOTHER'S MAIDEN NAME <b>Unknown</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Norman Johson</b>		
18. ADDRESS <b>1926 Orleans St.</b>			19. ADDRESS		

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Regeneration 2 yrs.</b> DUE TO <b>Arteriosclerosis</b> DUE TO <b>Hypertension</b>	CAUSE OF DEATH <b>Myocardial Regeneration 2 yrs.</b> <b>Arteriosclerosis</b> <b>Hypertension</b>	INTERVAL BETWEEN ONSET AND DEATH <b>generalized</b> <b>?</b>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK HOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **11/20**, 19**48** to **10/17**, 19**50** that I last saw the deceased alive on **10/16**, 19**50** and that death occurred at **3A** m., from the causes and on the date stated above.

23A. SIGNATURE <b>Louis J. Klemes</b>	23B. ADDRESS <b>2623 E. Mon. St.</b>	23C. DATE SIGNED <b>10/18/50</b>
--	---	-------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Oct 20/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>Oct 19 1950</b>	REGISTRAR'S SIGNATURE <b>William M. ...</b>	25. FUNERAL DIRECTOR <b>Philip ...</b>	ADDRESS <b>2026 Orleans St.</b>

RECEIVED

Mr. J. M. [illegible]  
[illegible]

[illegible]

11-28

RECEIVED  
NOV 28 1952



50 8934

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8934

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BENJAMIN F. BUTLER

2. DATE OF DEATH  
Oct. 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION  
(If not in hospital or institution, give street address or location)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

821 N. Eutaw St. ELTAW ST

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Nov. 26, 1895

9. AGE (In years last birthday)

54

10. Under 1 Year

Months

Days

11. Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Refrigeration Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Elec. Refrig. S. &amp; S. Co.

11. BIRTHPLACE (State or foreign country)

Greenville, S. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown Butler

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Reese Muckols, 309 W. Biddle Street

18. 581.0

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis of the liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William H. Wood

23B. CHIEF MEDICAL EXAMINER..... ☐ASSISTANT MEDICAL EXAMINER..... ☒

M.D. MEDICAL INVESTIGATOR

23C. DATE SIGNED

Oct. 16, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

10/19/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county)

Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Wood

25. FUNERAL DIRECTOR

H. M. Cook &amp; Co.

ADDRESS

1217 St. Paul Street

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1938 02

CERTIFICATE OF DEATH

bay

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8935

CERTIFICATE CORRECTED

10-19-50

BALTIMORE CITY HEALTH DEPARTMENT

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## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARGARET KERNS

2. DATE  
OF  
DEATH

OCT 18, 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

UNIVERSITY HOSP.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

16-06

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE ~~MARRIED~~  
WIDOWED, DIVORCED (Specify)Yrs.  
Mos.  
Days

8. DATE OF BIRTH 1896

Jan. 5, 1873

9. AGE (in years  
last birthday)

77 54

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Ford

14. MOTHER'S MAIDEN NAME

Moria

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Philip E. Kerns, Jr., 2921 Church Rd.

18. 410X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) CONGESTIVE HEART FAILURE

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) MITRAL STENOSIS

(C) RHEUMATIC CARDIOVASC. DIS.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from Oct 6, 1950 to Oct 18, 1950, that I last saw the  
deceased alive on Oct 18, 1950, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Edmund B. Middleton

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

Oct 18, 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

10/21/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore,

(State)

Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 19 1950

Huntington Williams, M.D.

H. B. Cook, Inc.

1217 St. Paul Street

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8936

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Bertha C. Page

2. DATE  
OF  
DEATH

Oct-17-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3036 St. Paul Street

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

at Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Maryland Baltimore City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore City

12-02

D. STREET ADDRESS (If rural, give location)

3036 St. Paul Street

c. Length of stay in Baltimore

78

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

May-7-1860

9. AGE (in years  
last birthday)

90

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR  
INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Fredericksburg, Va.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Edward L. Heinricher

14. MOTHER'S MAIDEN NAME

Charlotte J. Koch

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

none

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. Chas. W. Miller (daughter) 3036 St. Paul St.

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cardiovascular disease &  
congestive failure

6 mo

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

arteriosclerosis

? years

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 12/9/48, 19\_\_, to 10/17/50, 19\_\_, that I last saw the  
deceased alive on 10/17/50, 19\_\_, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Francis M. Kluck

M. D.

23B. ADDRESS

3406 St Paul St

23C. DATE SIGNED

10/18/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct-19-1950

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

OCT 19 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Stewart &amp; Morgan Co., 108 W. North Ave.

VS 150

City #1. 0932

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



*[The following text is extremely faint and illegible, appearing to be a list or index of items.]*

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50 8937

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8937

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Mary Louise Bloodsworth</i>		2. DATE OF DEATH <i>October 18 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>515 N. Curley St.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore City</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>at Home</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore City 7-01</i>	
c. Length of stay in Baltimore <i>12 years</i>		D. STREET ADDRESS (If rural, give location) <i>515 N. Curley Street</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Feb - 23 - 1906</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Housework</i>	9. AGE (in years last birthday) <i>44</i> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
13. FATHER'S NAME <i>William Stevens Fleming</i>		11. BIRTHPLACE (State or foreign country) <i>Princess Anne, Somerset Co., Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
16. SOCIAL SECURITY NO. <i>220-33-0221</i>		14. MOTHER'S MAIDEN NAME <i>Susie Frances Bradley</i>	
17. INFORMANT <i>Geo. W. Bloodsworth, Jr.</i>		ADDRESS <i>515 N. Curley Street</i>	
18. I <i>151X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Carcinomatosis</i> DUE TO <i>carcinoma of stomach.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>? Aug 8/50</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Emaciation - anorexia</i>			
19A. DATE OF OPERATION <i>Aug. 8/50</i>		19B. MAJOR FINDINGS OF OPERATION <i>carcinoma of stomach</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Aug 8, 1950</i> to <i>Aug 18, 1950</i> , that I last saw the deceased alive on <i>Oct 18, 1950</i> , and that death occurred at <i>2:00 p.m.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>Louis F. Krumler</i>		23B. ADDRESS <i>722 So. Kenwood Ave</i>	
23C. DATE SIGNED <i>Oct 19/50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Oct-21-1950</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Princess Anne</i>		24D. LOCATION (City, town, or county) (State) <i>Somerset Co., Maryland</i>	
25. FUNERAL DIRECTOR <i>Huntington Williams</i>		ADDRESS <i>Stewart &amp; Mowen Co. 108 W. North Ave</i>	
26. LOCAL REGISTRAR <i>(Louis F. Krumler)</i>			
City #1. 0466			

correct age is especially important. Physicians: please write the causes of death clearly and legibly.



500 50 8938

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8938

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HENRY CHIN

2. DATE  
OF  
DEATH

18 OCT 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

27 N. Carey

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)Good Samaritan Hosp  
27 N. Carey St

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

D. STREET ADDRESS (If rural, give location)

322 Park Ave 4-01

C. Length of stay in Baltimore

30 yrs

5. SEX

male

6. COLOR OR RACE

yellow (Chinese)

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

about 1895

9. AGE (In years last birthday)

55 yrs

10. Under 1 Year

Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laundry

10B. KIND OF BUSINESS OR INDUSTRY

Laundry-SELF

11. BIRTHPLACE (State or foreign country)

China

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

not known

14. MOTHER'S MAIDEN NAME

not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Chun Ling

ADDRESS

1523 Linden

18. 163X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Carcinoma of the lung

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7 Oct 1950, to 18 Oct 1950, that I last saw the deceased alive on 17 Oct 1950, and that death occurred at 4:00 A.M., from the causes and on the date stated above.

23. SIGNATURE

G. H. Henning

23A. ADDRESS

601 Wiggins Way

23C. DATE SIGNED

18 Oct 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

buried

24B. DATE

10/23/50

24C. NAME OF CEMETERY OR CREMATORY

Crown

24D. LOCATION (City, town, or county)

Woodlawn

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. H. Williams

25. FUNERAL DIRECTOR

H. H. Morris

ADDRESS

1325

VS 150

2908C

047d

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

1006

10

1006

10



360

50 8939

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8939

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Frank Chalkley Reid</i>		2. DATE OF DEATH <i>Oct 18/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Bellona Ave</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Edgewood Nursing Home</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore <i>16 yrs</i>		D. STREET ADDRESS (If rural, give location) <i>432 Kenneth Sp. 27-12</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Oct-24-1858</i>
9. AGE (In years last birthday) <i>92</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	
11. KIND OF BUSINESS OR INDUSTRY <i>Railway Express</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>David Reid</i>		14. MOTHER'S MAIDEN NAME <i>Emma Wilson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Mrs. Edgar Vandevort (sister)</i>		ADDRESS <i>432 Kenneth Sp.</i>	
18. <i>450.0</i>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Pneumonia (terminal)</i>	
ANTECEDENT CAUSES		(B) <i>Acute Rubeola Infection</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) <i>Similarity (art. 8000000)</i>	
19A. DATE OF OPERATION <i>none</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>no</i>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>March 1, 1950</i> , to <i>15 Oct</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>18 Oct</i> , 19 <i>50</i> , and that death occurred at <i>5:30</i> m., from the causes and on the date stated above.			
23A. SIGNATURE <i>Stodum Street</i>		23B. ADDRESS <i>112 Park Ave. Apt. 1</i>	
23C. DATE SIGNED <i>18 Oct 1950</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Oct-20-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Aspen Grove</i>	24D. LOCATION (City, town, or county) (State) <i>Bushington - Iowa</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>Oct 19 1950</i>	REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	25. FUNERAL DIRECTOR <i>Stewart Morris</i> ADDRESS <i>Balto.</i>	

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. The text is mirrored across the center fold.]*



536  
50 8940BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8940  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>KARL ERIK FERDINAND ANDERSSON</b>		2. DATE OF DEATH <b>October 11, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>US Marine Hospital</b> <b>Man Pk. Drive &amp; 31st St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>2-03</b>	
c. Length of stay in Baltimore <b>?</b> Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>1620 Shakespeare Street</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>? single</b>	8. DATE OF BIRTH <b>12/31/90</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ex-seaman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MARITIME</b>	9. AGE (In years last birthday) <b>59</b>
11. BIRTHPLACE (State or foreign country) <b>Sweden</b>		12. CITIZEN OF WHAT COUNTRY? <b>Sweden</b>	
13. FATHER'S NAME <b>Alfred Andersson</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>217-18-0334</b>	
17. INFORMANT <b>Records- US Marine Hospital, Balto, Md.</b>		ADDRESS <b>Records- US Marine Hospital, Balto, Md.</b>	

18. **420.1**

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Coronary sclerosis**

DUE TO

Unknown

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Massive pulmonary edema and congestion**

DUE TO

Unknown

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **2**

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **Oct. 10**, 19**50**, to **Oct. 11**, 19**50**, that I last saw the deceased alive on **Oct. 11, 1950**, and that death occurred at **10:45AM**, from the causes and on the date stated above.

23A. SIGNATURE  
**John L. Wilson, Medical Director**23B. ADDRESS  
**US Marine Hospital, Balto, Md.**23C. DATE SIGNED  
**10/17/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**OCT 19 1950****Huntington Williams, Jr. 4036-25th St.**

VS 150

**673 55****0940**

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CHOLERA, 1961-1962.

155 50 8941

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8941  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

IDA HUBMAN

2. DATE  
OF  
DEATH

10-19-50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

a. STATE

b. COUNTY

b. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Luthern Hospital

c. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

d. STREET ADDRESS (If rural, give location)

48-3531 Park Heights Ave

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Weaver Lubman - Same

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary Thrombosis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Hypertensive Cardio-Serous disease

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 1945 to Oct 19, 1950, that I last saw the deceased alive on Oct 18, 1950, and that death occurred at 3A m., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 19 1950

VS 150

093d

Full

3643

Reest

rd

NA 1304

222







50 8943

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8943

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HARRY

KERBER, JR.

2. DATE  
OF

DEATH October 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Dundalk

D. STREET ADDRESS (If rural, give location)

3024 Liberty Parkway

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Oct 11 1918

9. AGE (In years

last birthday)

32

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR

INDUSTRY

13. FATHER'S NAME

11. BIRTHPLACE (State or foreign country)

Balt

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Bess Kerber 12 Dundalk

18. E912.2

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Multiple fractures of pelvis

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Contusion of left thigh with secondary

XXXXX

infection

(C)

Pyelonephritis

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Industrial place

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

Bethlehem Steel Company, Sparrows Point

21F. HOW DID INJURY OCCUR?

Was squeezed between a machine

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

August 29, 1950

21E. INJURY OCCURRED  
WHILE AT WORK ☒ NOT WHILE  
AT WORK ☐22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

William V. Venable

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

October 18, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 19 1950

VS 151

N 808.0

690 3A

176.0

MEDICAL CERTIFICATION

correct age is especially important. In youths, please write the dates of birth clearly and legibly.

CERTIFICATE OF DEATH  
BALTIMORE CITY HEALTH DEPARTMENT

*[Faint, illegible text and markings on a death certificate form, including fields for name, date, and cause of death.]*

656  
50 8944BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8944  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GRAMMER, Mr. William

2. DATE  
OF  
DEATH

Oct. 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Church Home of Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland, Baltimore City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore City

D. STREET ADDRESS (If rural, give location)

6555 PARNELL AVE 26-06

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

8/23/1878

71

9. AGE (In years last birthday)

10 Under 1 Year 11 Under 1 Year 12 Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ex-Railroad Foreman

10B. KIND OF BUSINESS OR INDUSTRY

RAILROAD

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Andrew W. Grammer

14. MOTHER'S MAIDEN NAME

Mary McDonald

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Helen Davis 1924 SUNDERRY RD

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardiac Asthma

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Generalized Arteriosclerosis  
Senile Emphysema; Gastrojejunal ulcer

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 10/5, 1950, to 10/16, 1950, that I last saw the deceased alive on 10/16, 1950, and that death occurred at 11:00 A. M., from the causes and on the date stated above.

23A. SIGNATURE

H Reed Carroll

23B. ADDRESS

M. D.

Church Home &amp; Hospital

23C. DATE SIGNED

10/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 19 1950

Washington Williams, M.D.

ELLERICH FUNERAL HOME

DUNDALK, MD.

VS 150

523 50

1170

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

1988

10

1988

10

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1988

REPORT OF THE

COMMISSIONER OF

THE STATE OF NEW YORK

TO THE SENATE

AND ASSEMBLY

FOR THE YEAR 1987

ALBANY, NEW YORK

1988

STATE OF NEW YORK

COMMISSIONER OF

THE STATE OF NEW YORK

TO THE SENATE

AND ASSEMBLY

FOR THE YEAR 1987

ALBANY, NEW YORK

1988

620  
50 8945BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8945

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Miss Marion Price</i>			2. DATE OF DEATH <i>OCT 17, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i> <i>Baltimore 18, Maryland</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>16-05</i>		
D. STREET ADDRESS (If rural, give location) <i>2303 Arunah Ave.</i>			5. SEX <i>Female</i>		
6. COLOR OR RACE <i>white</i>			7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>		
8. DATE OF BIRTH <i>April 1, 1877</i>			9. AGE (In years last birthday) <i>73</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>school teacher (rtd)</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Public School</i>		
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Jerome W. Price</i>			14. MOTHER'S MAIDEN NAME <i>Sophia McIntire</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Miss Edith Price</i>			ADDRESS <i>2303 Arunah Ave.</i>		

18. <i>420.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary thrombosis</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>5 hours</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>arteriosclerotic heart disease</i> DUE TO		<i>3 years</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes Mellitus</i>		<i>? years</i>

19A. DATE OF OPERATION <i>✓</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Oct 17, 1950*, to *Oct 17, 1950*, that I last saw the deceased alive on *Oct 17, 1950*, and that death occurred at *10:10 P. m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Alfred S. Nelson</i>	23B. ADDRESS <i>Union Memorial Hospital</i> <i>Baltimore 18, Maryland</i>	23C. DATE SIGNED <i>Oct 17, 1950</i>
---	---	---

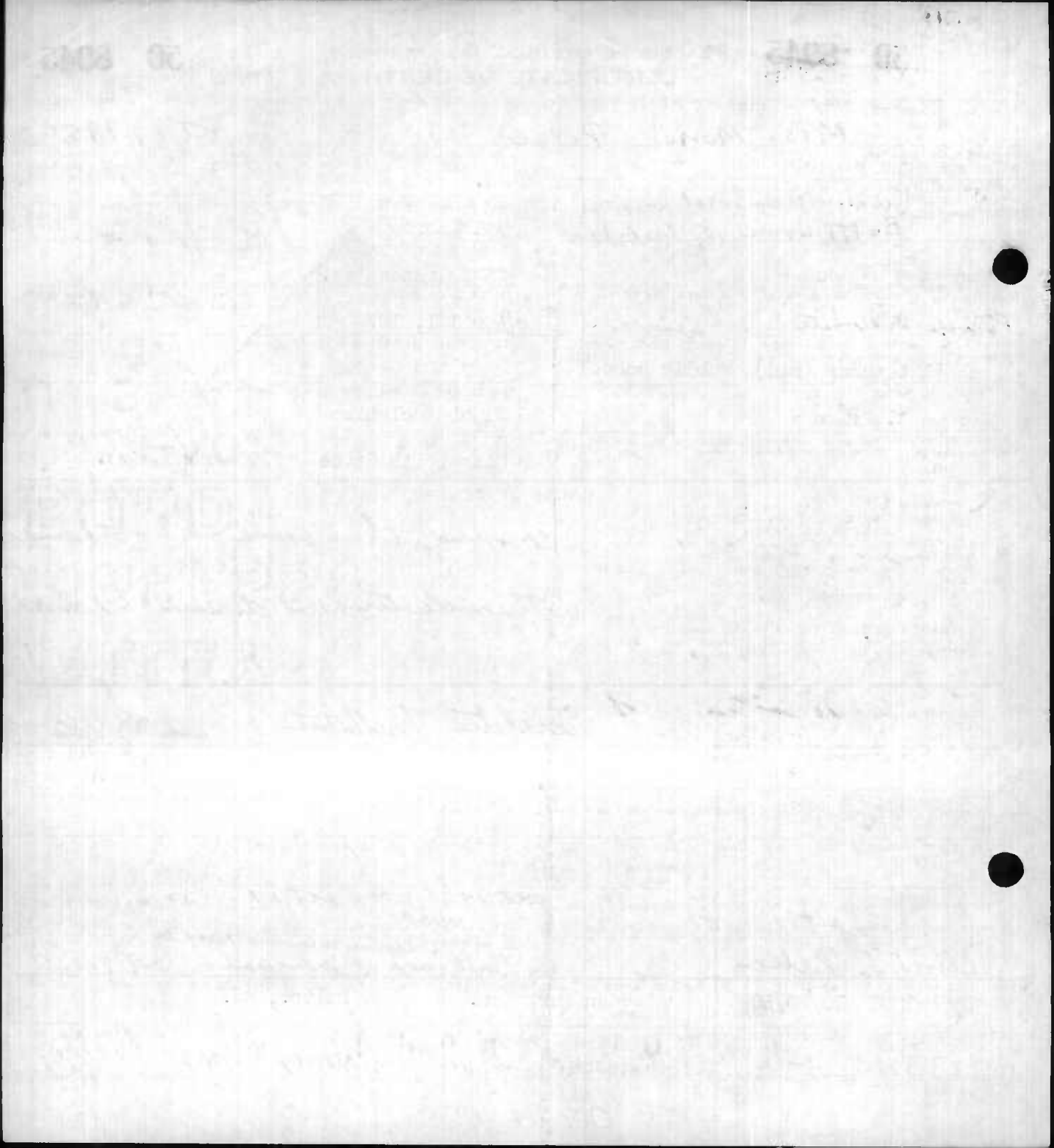
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>buried</i>	24B. DATE <i>10/20/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>Balto., Md.</i>
--	------------------------------	---	---

DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 19 1950</i>	REGISTRAR'S SIGNATURE <i>Wm. J. Pickens &amp; Sons - Balto.</i>	25. FUNERAL DIRECTOR <i>Wm. J. Pickens &amp; Sons - Balto.</i>	ADDRESS <i>Md.</i>
--	--	---	-----------------------

VS 150

0938V

061.0





500  
50 8946BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8946

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN H. SKEEN

2. DATE  
OF DEATH Oct. 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION 6203 Blackburn Lane4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Md. B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 27-12D. STREET ADDRESS (If rural, give location)  
6203 Blackburn Lane

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

May 19, 1883

9. AGE (In years  
last birthday)

67

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Lawyer

10B. KIND OF BUSINESS OR  
INDUSTRY

SELF

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John T. Skeen

14. MOTHER'S MAIDEN NAME

Eliza Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
no16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Mrs. Alice A. Skeen 6203 Blackburn Lane

18. 203X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Multiple Myeloma

3 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) —  
DUE TO —  
(C) —II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from March 31, 1948, to October 18, 1950, that I last saw the deceased alive on Oct 18, 1950, and that death occurred at 2:00 p. m., from the causes and on the date stated above.

23A. SIGNATURE

H. S. Chalfant

M. D.

23B. ADDRESS

6210 York Road

23C. DATE SIGNED

Oct 19 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
Burial

24B. DATE

10/21/50

24C. NAME OF CEMETERY OR CREMATORY

Greenmount Cem.

24D. LOCATION (City, town, or county) (State)

5 Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. F. Tichner &amp; Sons - Balto Md.

ADDRESS

OCT 19 1950

VS 150

0558U

0552

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

30 KALE

30 KALE



635  
50 8947BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8947  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM

BRITTON

2. DATE  
OF  
DEATH

Oct. 14, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
a. STATE

Maryland

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 41-02

d. STREET ADDRESS (If rural, give location)

718 W. Saratoga St.

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

1-13-1871

9. AGE (In years  
last birthday)

79

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Junkie

10b. KIND OF BUSINESS OR  
INDUSTRY

Self Employed

11. BIRTHPLACE (State or foreign country)

Hassell, William N. C.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Irvin Britton

14. MOTHER'S MAIDEN NAME

Harriet Bowles

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

Alga B. Clark - 918

Hill Ave.

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23a. SIGNATURE

Stanley H. Dunsen

M.D.

23b. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR23c. DATE SIGNED  
Oct. 14, 195024a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

7109 05

CERTIFICATE OF DEATH

7109 05

500  
50 8948  
JL - 142105BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8948  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas Payne

2. DATE  
OF  
DEATH

Oct. 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street address or location)  
Baltimore City Hospitals  
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

115 W. 29th Street -18

Yrs.  
Mos.  
Days

Length of stay in Baltimore

30 yrs.

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Wid.

8. DATE OF BIRTH

May 15, 1872

9. AGE (In years

last birthday)

78

10 Under 1 Year

11 Under 24 Hours

Months: Days

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Janitor

10B. KIND OF BUSINESS OR  
INDUSTRY

Apt. House

13. FATHER'S NAME

John Foot

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Martha

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

B. C. H. Records, 4940 Eastern Ave.

ADDRESS

18. 002X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary Tuberculosis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

Far advanced

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-30-50, 19, to Oct. 16, 1950, that I last saw the  
deceased alive on Oct. 16, 1950 and that death occurred at 9.35pm, from the causes and on the date stated above.

23A. SIGNATURE

P. S. Dozen M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

10-17-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Burial 10-20-1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem. Balto. Md.

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Mrs. Katie Williams

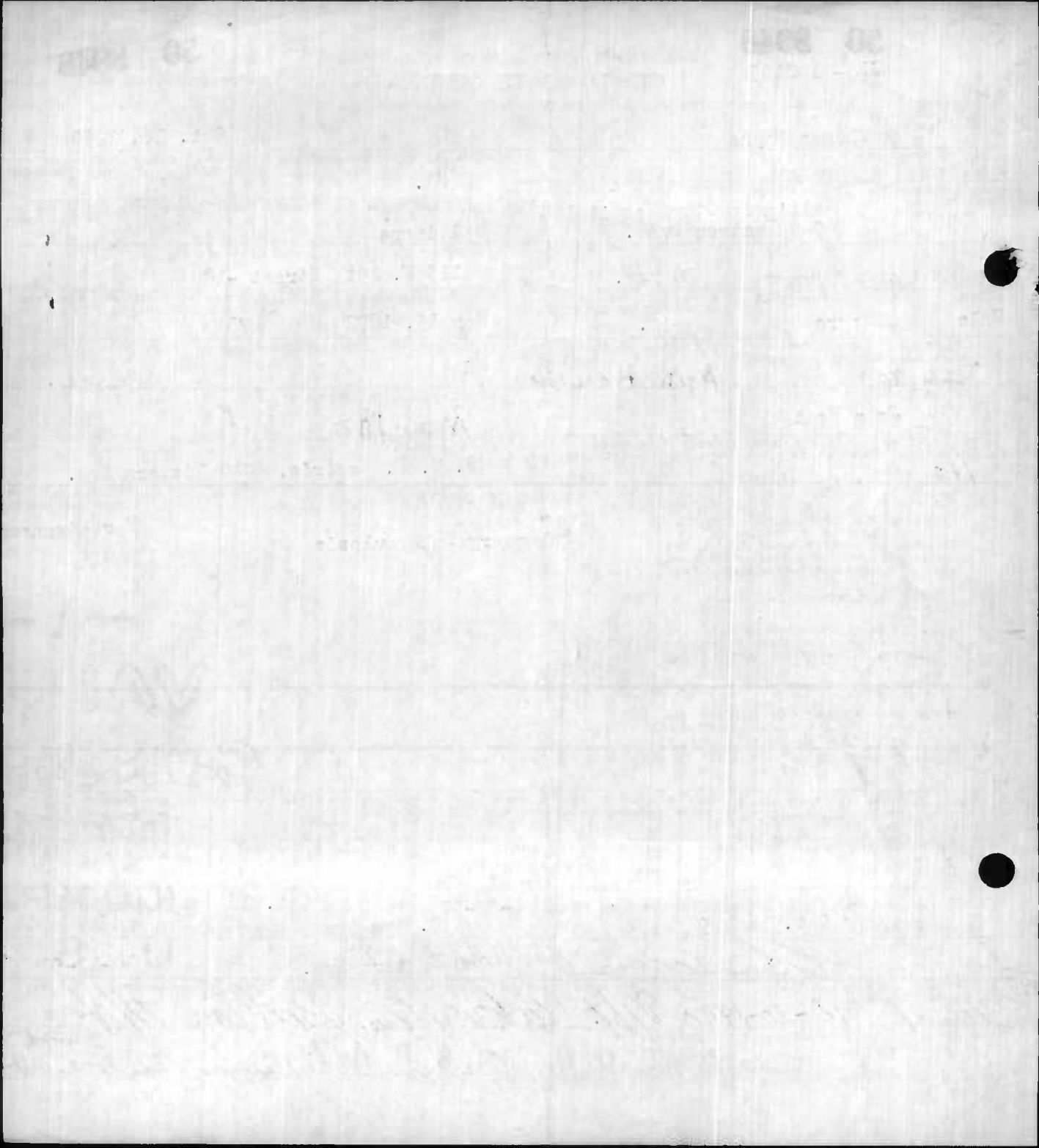
ADDRESS

322 N. Schenck St.

OCT 19 1950

VS 150

0136





50 8949

50 8949

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SYLVAN SENKER

2. DATE  
OF  
DEATH

19 OCTOBER 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

UNION MEMORIAL HOSPITAL

Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

OWNER

10B. KIND OF BUSINESS OR INDUSTRY

Rug CLEANING

13. FATHER'S NAME

MR SAMUEL SENKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

27 JANUARY 1888

9. AGE (in years last birthday)

62

If Under 1 Year Months: Days

8 22

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

14. MOTHER'S MAIDEN NAME

BABETTA GREENHOOD

17. INFORMANT

VEROME SENKER

SON ADDRESS

(SAME)

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCTION, ACUTE

4+ HRS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ARTERIO-SCLEROTIC HEART DISEASE

10+ YRS

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 19 OCT 8:20AM, 1950, to 9AM 19 OCT, 1950 that I last saw the deceased alive on 9AM 19 OCT, 1950, and that death occurred at 9A m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 19 1950

Huntington Hills, Md

Union Memorial Hospital 19 Oct 1950  
Hebrew Friendship Fory St Balto  
Doris Goldheimson 1802 E. 1st

1. The first part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

2. The second part of the document is a list of names and addresses, similar to the first part. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

3. The third part of the document is a list of names and addresses, similar to the first two parts. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

4. The fourth part of the document is a list of names and addresses, similar to the first three parts. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

5. The fifth part of the document is a list of names and addresses, similar to the first four parts. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

6. The sixth part of the document is a list of names and addresses, similar to the first five parts. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

7. The seventh part of the document is a list of names and addresses, similar to the first six parts. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

8. The eighth part of the document is a list of names and addresses, similar to the first seven parts. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

9. The ninth part of the document is a list of names and addresses, similar to the first eight parts. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

10. The tenth part of the document is a list of names and addresses, similar to the first nine parts. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 8950**

**50 8950**  
**S-300**  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>William Edward Scott</b>			2. DATE OF DEATH <b>Oct. 14, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
5. FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION <b>P.D. at spot where found at</b> <b>1500 block Maryland Ave. Just West of Southern</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
Entrance to Md. Ave. Bridge Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>1715 Maryland Ave.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>? 1890</b>	9. AGE (In years last birthday) <b>60</b>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	11. BIRTHPLACE (State or foreign country) <b>FREDICKSBURG, VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>EDWARD SCOTT</b>			14. MOTHER'S MAIDEN NAME <b>LOUISA COURTNEY</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>THELMA A. MITCHELL</b>		

18. <b>E974X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH  (A) <b>Asphyxiation due to strangulation by hanging</b> DUE TO  (B) _____ DUE TO  (C) _____  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
--	--

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>public place</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Southern ent. to Md. Ave. Found at 1500 block Md. Ave. just West of</b>	21D. TIME (Month) (Day) (Year) (Hour) of INJURY <b>Oct. 14, 1950 abt. 7 P.m.</b>	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Hanged self by rope from tree</b>		

22. I certify that I took charge of the remains described above, held an <b>Insp. &amp; Insp.</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
23A. SIGNATURE <b>Stanley H. Dareschewsky</b> M.D.	23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/>	23C. DATE SIGNED <b>Oct. 14, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>10/20/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN</b>	24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 19 1950</b>		REGISTRAR'S SIGNATURE <b>William A. Jackson</b>	25. FUNERAL DIRECTOR ADDRESS <b>Wm. A. JACKSON - 916 PEGNA. AVE.</b>

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

0508

02

0508

02

CENTRAL OFFICE OF DEATH

1977



802 Cathedral  
15 W. MADISON.

1208 02







A-516  
50 8953BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8953

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Mrs. Nancy Ambrose</u>			2. DATE OF DEATH <u>10/19/50</u>		
3. PLACE OF DEATH: A. <u>Baltimore City, Maryland</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION <u>University Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>BALTIMORE</u>		
D. STREET ADDRESS (If rural, give location) <u>3327 Spaulding Ave.</u>			E. <u>27-18</u>		
5. SEX <u>F</u>			6. COLOR OR RACE <u>W</u>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>			8. DATE OF BIRTH <u>March 28, 1879</u>		
9. AGE (In years last birthday) <u>71</u>			10. UNDER 1 Year Months: Days: Hours: Min.		
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland, U.S.A.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James Lorell</u>			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Mr. Alfred S. Ambrose</u>			ADDRESS <u>3327 Spaulding Ave.</u>		
18. <u>331X</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Intracerebral Hemorrhage</u> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Arteriosclerosis</u> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u> 19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10/17/50</u> , 19 <u>50</u> , to <u>10/19</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>10/19</u> , 19 <u>50</u> , and that death occurred at <u>12:30</u> m., from the causes and on the date stated above.					
23A. SIGNATURE <u>[Signature]</u>		23B. ADDRESS <u>University Hosp.</u>		23C. DATE SIGNED <u>10/19/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Oct. 21/50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25. FUNERAL DIRECTOR <u>Long &amp; Byers</u>		ADDRESS <u>5005 Park Heights</u>	

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Albert A. Frazer, Sr.

2. DATE  
OF  
DEATH

Oct. 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR Windsor Nursing Home  
INSTITUTION 3025 Windsor Ave.,4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE Md.  
B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 15-06D. STREET ADDRESS (If rural, give location)  
3025 Walbrook Ave.

c. Length of stay in Baltimore

80 - Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Widower

8. DATE OF BIRTH

10/19/1864

9. AGE (In years  
last birthday)

85

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
Retired Carpenter10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Not Known

14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

218-22-1511

17. INFORMANT

ADDRESS

Mr. Albert A. Frazer, Jr. 3025 Walbrook Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 20, 1950, to Oct 18, 1950, that I last saw the  
deceased alive on Oct 16, 1950, and that death occurred at 4 a m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

10-21-1950

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county) (State)

Baltimore,

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 19 1950

G. Howard Strong

3207 W. North Ave/

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8955  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOSEPH SALBECK</b>		2. DATE OF DEATH <b>Oct. 17, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland St.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>1926</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>4230 Cardwell Avenue 5200</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Sept. 26, 1902</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL INDUSTRY Beth. Steel Corp.</b>	9. AGE (In years last birthday) <b>48</b>
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Ackeide Salbeck</b>		14. MOTHER'S MAIDEN NAME <b>Frances Scheibel</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-07-7134</b>	
17. INFORMANT <b>Johanna Salbeck, wife, above</b>		ADDRESS	

18. <b>331X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b> DUE TO <b>Arterio Sclerosis</b> DUE TO <b>Unknown</b>	CAUSE OF DEATH <b>Cerebral Hemorrhage</b> <b>Arterio Sclerosis</b> <b>Unknown</b>	INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hours</b> <b>Unknown</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>February 9, 1949</b> , to <b>Oct. 17, 1950</b> , that I last saw the deceased alive on <b>Oct. 16, 1950</b> , and that death occurred at <b>3 P. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Philbert Artigiani</b>		23B. ADDRESS <b>2942 E. Fayette St.</b>		23C. DATE SIGNED <b>10/19/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>October 21, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>4430 Belair Rd. Balto. Md.</b>		25. FUNERAL DIRECTOR <b>Schmunek Funeral Home, Inc.</b>		ADDRESS <b>2601-3-5 E. Madison St.</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>Thurston Williams, M.D.</b>		25. FUNERAL DIRECTOR ADDRESS	

OCT 19 1950

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20-8932

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CERTIFICATE OF DEATH

20-8932

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BALTIMORE CITY HEALTH DEPARTMENT

50 8956

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH F. NOCAR

2. DATE  
OF  
DEATH

Oct. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2121 Mura St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2121 Mura Street

c. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

March 21, 1908

9. AGE (In years  
last birthday)

42

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

ech. Service Man

10B. KIND OF BUSINESS OR  
INDUSTRYREPAIRS. EQUIPT.  
Bozman Brothers

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

James Nocar

14. MOTHER'S MAIDEN NAME

Theresa Komenda

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

Army - World War 2

16. SOCIAL  
SECURITY NO.

217-03-5695

17. INFORMANT

ADDRESS

Margaret Nocar, wife, above

18. 163x

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Carcinoma of Lung

DUE TO

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/18, 1950, to 10/17, 1950, that I last saw the  
deceased alive on 10/16, 1950, and that death occurred at 5:40 p. m., from the causes and on the date stated above.

23A. SIGNATURE

C. W. Weiss

M. D.

23B. ADDRESS

1927 E. North Ave.

23C. DATE SIGNED

10/18/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 20, 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National Cem.

24D. LOCATION (City, town, or county)

5501 Frederick Ave.

(State)

Balto. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Schmidt Funeral Home, Inc.

ADDRESS

2601-3-5 E. Madison St.

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

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DER BRIGADE CHIEF

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50 8957BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8957  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN RINAUDO</b>		2. DATE OF DEATH <b>10-18-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>8-05</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. JOSEPH'S HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTO.</b>	
C. Length of stay in Baltimore <b>13</b> <small>Yrs. Mon. Days</small>		D. STREET ADDRESS (If rural, give location) <b>1761 Darley Ave.</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>2-23-12</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	9. AGE (In years last birthday) <b>38</b>
11. BIRTHPLACE (State or foreign country) <b>LOUISIANA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Angelo Rinaudo</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Mazzola</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Marianne Rinaudo 1761 Darley Ave</b>	

18. <b>540.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CHRONIC STARVATION AND DEHYDRATION</b> DUE TO <b>ORGANIC PYLORIC OBSTRUCTION</b> DUE TO <b>PEPTIC ULCER</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>MENTAL DEFICIENCY</b>	CAUSE OF DEATH <b>CHRONIC STARVATION AND DEHYDRATION</b> <b>ORGANIC PYLORIC OBSTRUCTION</b> <b>PEPTIC ULCER</b> <b>MENTAL DEFICIENCY</b>	INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>9 mos.</b> <b>CONGEN.</b>
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19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>10-15, 1950</b> to <b>10-18, 1950</b> that I last saw the deceased alive on <b>10-17, 1950</b> , and that death occurred at <b>3<sup>30</sup> A.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Joseph Krizan</b>		23B. ADDRESS <b>1760 N. Caroline St</b>		23C. DATE SIGNED <b>10-18-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 21/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>	
24D. LOCATION (City, town, or county) <b>Balt. Md.</b>		24E. FUNERAL DIRECTOR <b>Frank Miller</b>		24F. ADDRESS <b>322 S. High St.</b>	

OCT 19 1950

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THE NATIONAL BUREAU OF STANDARDS

WASHINGTON, D. C. 20540



R-163  
50 8958BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8958

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Alfred Robertson</u>			2. DATE OF DEATH <u>10/17/50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>206 S Eden St. Md.</u> B. COUNTY <u>Baltimore</u>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Mary Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>3-02</u>		
c. Length of stay in Baltimore <u>10</u> Days			D. STREET ADDRESS (If rural, give location) <u>206 S Eden St</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9/11/88</u>		9. AGE (In years last birthday) <u>62</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or last occupation) <u>WARDEN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SHOPYARD</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Robertson</u>			14. MOTHER'S MAIDEN NAME <u>Anna Edwards</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-05-2320</u>		17. INFORMANT <u>Mary Robertson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-05-2320</u>		ADDRESS <u>206 S. Eden St.</u>	

18. <u>450.0</u>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)	(A) <u>Coronary heart failure</u> DUE TO	
ANTECEDENT CAUSES	(B) <u>Coronary artery revascularization</u> DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C) <u>Chronic pericarditis</u> DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <u>10/17/50</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10/17</u> <sup>19<u>50</u></sup> to <u>10/17</u> <sup>19<u>50</u></sup> , that I last saw the deceased alive on <u>10/17</u> <sup>19<u>50</u></sup> and that death occurred at <u>9:30 p.m.</u> <sup>19<u>50</u></sup> , from the causes and on the date stated above.					
23A. SIGNATURE <u>E. Richard Frazer</u> M.D.		23B. ADDRESS <u>Berry Hook</u>		23C. DATE SIGNED <u>10/18/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Oct. 20 1950</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>4430 Belair Rd. Balt. Md.</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>Oct 19 1950</u>		REGISTRAR'S SIGNATURE <u>Thurston Williams</u>		25. FUNERAL DIRECTOR <u>Frank Wells</u> ADDRESS <u>322 S. High St.</u>	

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OFFICE OF THE DIRECTOR  
CENTRAL INTELLIGENCE AGENCY

21-08-1940

1. The following information was received from the  
Office of the Director, Central Intelligence Agency, on  
August 21, 1940:

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8959

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Carmela Mangione

2. DATE

OF DEATH Oct. 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5018 Belair Rd.

Length of stay in Baltimore

22 yr.

Yrs.  
Mos.  
Days

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

March 7 1882

9. AGE (In years  
last birthday)

68

If Under 1 Year  
Months: Days

7 11

If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Paolo Marasa

14. MOTHER'S MAIDEN NAME

Lucia Navarra

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Maria Russo (Daughter) 5018 Belair Rd

18. 434.2

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Congest Heart Failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Cardiac Asthma; Cardiac Asthma;

DUE TO Terminal Lobar Pneumonia

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 15, 1950 to October 18, 1950, that I last saw the  
deceased alive on Oct. 18, 1950, and that death occurred at 10:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Oct. 21/50

Holy Redeemer Cem.

4430 Belair Rd. Balt. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 19 1950

322 S. High St.

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **50 8960**

BIRTH NO.

**50 8960**

1. NAME OF DECEASED (Type or Print) <b>NINA CECILIA JACKSON (MRS. OSCAR)</b>		2. DATE OF DEATH <b>OCT. 18, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 12 77-12</b>	
Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>6006 ANDERSON AVE.</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> <b>WIDOWED</b> DIVORCED (Specify)	8. DATE OF BIRTH <b>Nov. 23, 1867</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	9. AGE (In years last birthday) <b>82</b> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM KELLY</b>		14. MOTHER'S MAIDEN NAME <b>ANNA DAY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NUMBER <b>218-01-3588</b>	
17. INFORMANT <b>PATIENT</b>		ADDRESS	
18. <b>42010</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>PULMONARY EMBOLUS, ACUTE</b> DUE TO (B) <b>PHLEBO-THROMBOSIS</b> DUE TO (C) <b>ARTERIO-SCLEROTIC HEART DISEASE WITH CONGESTIVE HEART FAILURE</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN</b> <b>24 HRS +</b> <b>10 DAYS +</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>OCT. 4, 1950</b> , to <b>OCT. 18, 1950</b> , that I last saw the deceased alive on <b>OCT. 18, 1950</b> , and that death occurred at <b>3:05 P.M.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Wallace H. Buttrick</b> M. D.		23B. ADDRESS <b>Union Memorial Hospital</b>	
23C. DATE SIGNED <b>18 Oct 1950</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>10/21/50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 19 1950</b>		REGISTRAR'S SIGNATURE <b>Henry Sander &amp; Sons, Inc.</b> ADDRESS <b>BALTO., 13, Md.</b>	





correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-652 50 8961		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		50 8961 Registered No.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Raymond Joseph Barnes</i>			2. DATE OF DEATH <i>Oct 18, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore -13 26-03</i>		
length of stay in Baltimore			O. STREET ADDRESS (If rural, give location) <i>3415 Kentucky Ave.</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Mar 15, 1915</i>	9. AGE (In years last birthday) <i>32</i>	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Brick Layer, Bethlehem (Steel) Co.</i>			11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		
13. FATHER'S NAME <i>James N. Barnes</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes World War II</i>			16. SOCIAL SECURITY NO. <i>218-01-3027</i>		
17. INFORMANT <i>Mrs. Norma E. Barnes (wife)</i>			ADDRESS <i>3415 Kentucky Ave</i>		
18. <i>570.2</i> CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) <i>Intestinal gangrene</i> <i>17 days</i>	
ANTECEDENT CAUSES				(B) <i>Myocardial thrombosis</i> <i>21 days</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(C) <i></i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>Sept 30, 1950</i>		19B. MAJOR FINDINGS OF OPERATION <i>small intestine gangrene, bowel duct thrombosis</i>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>9/29</i> , 1950, to <i>10/18</i> , 1950, that I last saw the deceased alive on <i>10/18</i> , 1950, and that death occurred at <i>5:30 A.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>G. E. Smart</i>		23B. ADDRESS <i>M. O. Maryland Gen Hosp.</i>		23C. DATE SIGNED <i>10/15/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Oct. 21, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park. Cem. Baltimore Md</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>		24E. FUNERAL DIRECTOR <i>HENRY SANDER &amp; SONS, INC</i>		24F. ADDRESS <i>Baltimore Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 19 1950</i>		REGISTRAR'S SIGNATURE <i>Thurston Williams, Md</i>		VS 150	

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A-536  
50 8962BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8962  
Registered No.BIRTH NO. 0018020

1. NAME OF DECEASED (Type or Print) <u>Charles Robert Anderson</u>			2. DATE OF DEATH <u>10-19-50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>12-05</u>		
Length of stay in Baltimore <u>2 Mos.</u>			D. STREET ADDRESS (If rural, give location) <u>217 E. Lafayette Ave</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>S</u>	8. DATE OF BIRTH <u>8-22-50</u>	9. AGE (In years last birthday) <u>1</u>	10. Under 1 Year Months: Days <u>27</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Carl Anderson</u>			14. MOTHER'S MAIDEN NAME <u>Jane Woodruff</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		

18. <u>756.0</u>	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) <u>Suffocation</u>	<u>3 hrs</u>
ANTECEDENT CAUSES		(B) <u>Aspiration stomach contents</u>	<u>-</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) <u>Stress</u>	<u>5 days</u>

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Post-op gastrojejunostomy

19A. DATE OF OPERATION <u>8-30-50</u>	19B. MAJOR FINDINGS OF OPERATION <u>Stenosis duodenum</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>9-1</u> , 19 <u>50</u> to <u>10-19</u> , 19 <u>50</u> that I last saw the deceased alive on <u>10-19</u> , 19 <u>50</u> and that death occurred at <u>2:30</u> p.m., from the causes and on the date stated above.		
23A. SIGNATURE <u>Dr. Fredrick</u> M. D.	23B. ADDRESS <u>New. Hwy.</u>	23C. DATE SIGNED <u>10-19-50</u>

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	24B. DATE <u>10/20/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>OCT 19 1950</u>	REGISTRAR'S SIGNATURE <u>Wm. J. Pickens</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickens</u>	ADDRESS <u>Balto. Md.</u>

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHX 50 8963  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EARL VINCENT QUINN		2. DATE OF DEATH Oct. 18, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Va. B. COUNTY V-43	
B. FULL NAME OF HOSPITAL OR INSTITUTION US Marine Hospital Wyman Pk. Drive & 31st St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Norfolk	
Length of stay in Baltimore 28 days Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 912 Little Creek Road	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2/5/17
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mate		10B. KIND OF BUSINESS OR INDUSTRY Seafarer	9. AGE (In years last birthday) 33
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clyde Riley Quinn		14. MOTHER'S MAIDEN NAME Ada Austin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 231-01-3764	
17. INFORMANT Record- US Marine Hospital, Balto, Md.		ADDRESS	

18. 204.1	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Chronic myelogenous leukemia DUE TO	Unknown
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from Sept. 20, 1950, to Oct. 18, 1950 that I last saw the deceased alive on Oct. 18, 1950 and that death occurred at 12 noon, from the causes and on the date stated above.				
23A. SIGNATURE John L. Wilson, Medical Director		23B. ADDRESS US Marine Hospital, Balto, Md.		23C. DATE SIGNED 10/19/50
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal	24B. DATE 10/19/50	24C. NAME OF CEMETERY OR CREMATORY -	24D. LOCATION (City, town, or county) (State) Norfolk, Va.	

DATE RECEIVED BY LOCAL REGISTRAR OCT 19 1950	REGISTRAR'S SIGNATURE Huntington Williams	25. FUNERAL DIRECTOR H. M. J. Pickens & Sons	ADDRESS Balto
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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

50 8083

50 8083

CERTIFICATE OF DEATH

50 8083

50 8083





50 8964  
H-623

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8964

1. NAME OF DECEASED (Type or Print) <b>ANNA MARIE HARGADON</b>		2. DATE OF DEATH <b>10/19/50.</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>The Hosp. for the women of Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 20-06</b>	
d. STREET ADDRESS (If rural, give location) <b>339 Fonthill Ave.</b>		e. LENGTH OF STAY IN BALTIMORE <b>60</b> Yrs. Mos. Days	
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>June 25 1890</b>
9. AGE (In years last birthday) <b>60</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin Hartman</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Kelly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Josephine Hargadon Fonthill Ave</b>		18. ADDRESS <b>339 Fonthill Ave</b>	
18. <b>443X</b> CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>(A) Hypertensive Cardiovascular Disease</b>		DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B) Congestive heart failure</b>		DUE TO	
<b>(C) Pulmonary infection</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19a. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>10/16</b> , 19 <b>50</b> , to <b>10/19</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>10/19</b> , 19 <b>50</b> , and that death occurred at <b>4:30</b> m., from the causes and on the date stated above.			
23a. SIGNATURE <b>Mark E. Hall, Jr.</b>		23b. ADDRESS <b>Woman's Hosp.</b>	
23c. DATE SIGNED <b>10/19/50</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>10/23/50</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Landon Park</b>		24d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 19 1950</b>		REGISTRAR'S SIGNATURE <b>Thurston Williams</b>	
FURNERAL DIRECTOR <b>Robert B. M. Walters</b>		PREPARED BY <b>Pratt &amp; Jendry</b>	

1908-05

1908-05

Personnel - Room 10  
1908-05

C-636  
50 8965BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8965  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		DIANE G. CARTER		2. DATE OF DEATH Oct. 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 1625 W. Fayette St.				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 19-02	
6. LENGTH OF STAY IN BALTIMORE 6 yrs.				D. STREET ADDRESS (If rural, give location) 1625 W. Fayette St.	
7. SEX Female	8. COLOR OR RACE White	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	10. DATE OF BIRTH July 11, 1939	11. AGE (In years last birthday) 11	12. H Under 1 Year Months: Days H Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME Harold C.			14. MOTHER'S MAIDEN NAME Anna L. Seagle		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Anna L. Carter			ADDRESS Same		

18. 753.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple congenital deformities of  
DUE TO brain and intestinal tract

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....☒ M.D. ASSISTANT MEDICAL EXAMINER.....☐ MEDICAL INVESTIGATOR.....☐23C. DATE SIGNED  
Oct. 19, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



correct age is extremely important. Physicians: please write the causes of death clearly and legibly.

420

REA -141964

50

8966

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8966

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Albert Gillis</b>		2. DATE OF DEATH <b>October 18, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>20-04</b>	
D. STREET ADDRESS (If rural, give location) <b>2420 W. Lombard Street</b>		E. LENGTH OF STAY IN BALTIMORE <b>28 years</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>July 17, 1889</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>unemployed</b>	9. AGE (In years, last birthday) <b>61</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <b>Albert Gillis</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Esworthy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>(Yes, no or unknown)</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Records: B. C. H. 4940 Eastern Avenue</b>		ADDRESS _____	

18. **002X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Tuberculous Lobar Pneumonia**

**2 Weeks**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) \_\_\_\_\_

19A. DATE OF OPERATION **✓**

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK AT ☐ WHILE NOT AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **9-25**, 19**50** to **10-18**, 19**50** that I last saw the deceased alive on **10-18**, 19**50**, and that death occurred at **11:30 P.**, from the causes and on the date stated above.

23A. SIGNATURE **[Signature]**

M. D.

23B. ADDRESS

**4940 Eastern Avenue**

23C. DATE SIGNED

**10-19-50**

24A. BURIAL, CREMATION, REMOVAL (Specify)  
**Burial**

24B. DATE

**Oct. 21, 1950**

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

**Howard Co.,**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

**OCT 19 1950**

REGISTRAR'S SIGNATURE

**[Signature]**

25. FUNERAL DIRECTOR

**C. M. Waltz, Winfield, Md.**

ADDRESS

VS 150

97099

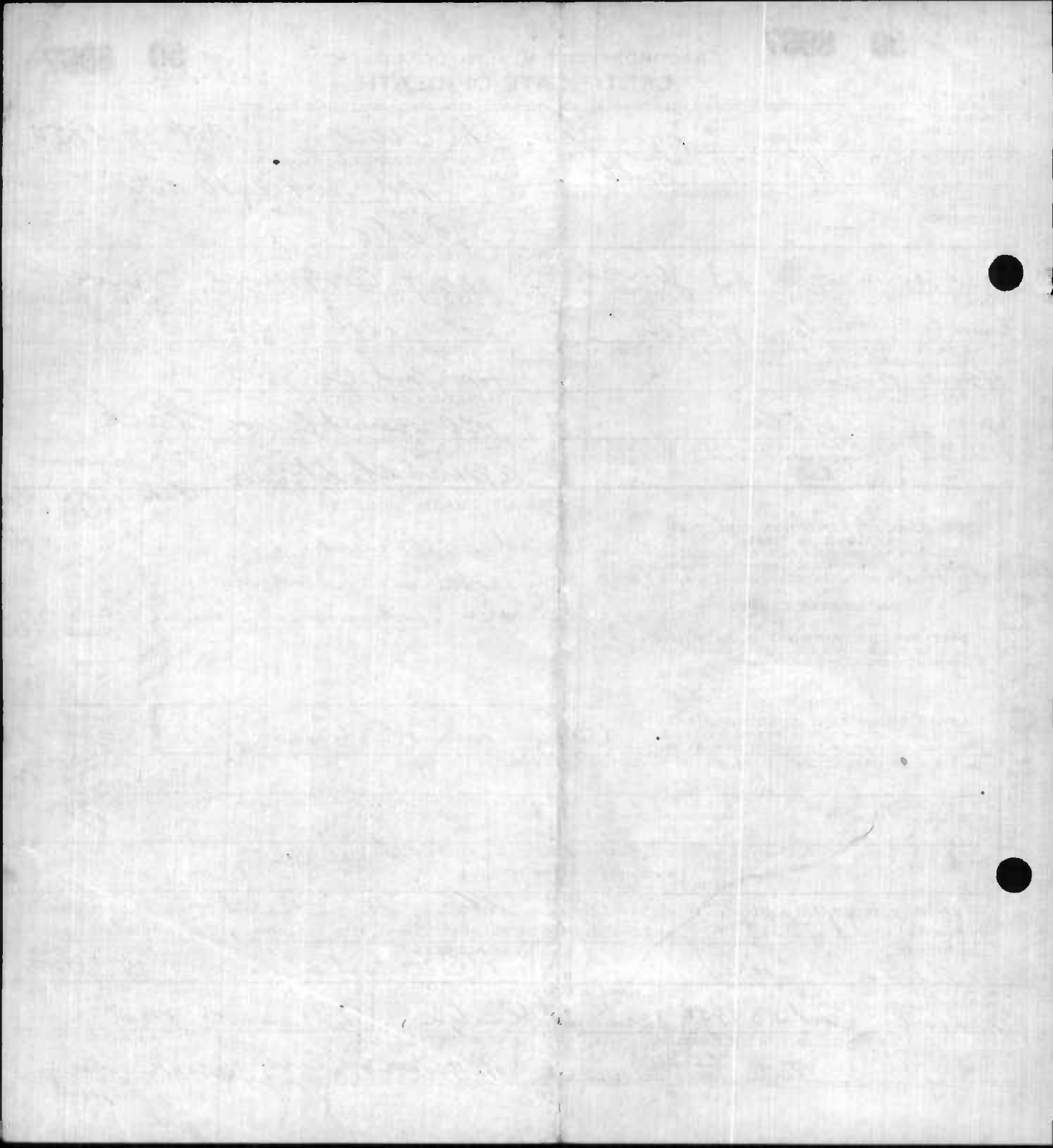
0136





correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5330 8967		BALTIMORE CITY HEALTH DEPARTMENT		50 8967	
BIRTH NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <i>Annie Mullen St Clair</i>			2. DATE OF DEATH <i>Oct 19 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1109 Argonne Blvd.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>—</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 9-02</i>		
Length of stay in Baltimore <i>13 years</i>			D. STREET ADDRESS (If rural, give location) <i>1109 Argonne Drive</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Oct 1 1866</i>	9. AGE (in years last birthday) <i>84</i>	10. Under 1 Year Months: <i>0</i> Days: <i>18</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)			11. BIRTHPLACE (State or foreign country) <i>Harford co md</i>		12. CITIZEN OF WHAT COUNTRY? <i>—</i>
13. FATHER'S NAME <i>Wm K Lytle</i>			14. MOTHER'S MAIDEN NAME <i>Margaret Ann Clark</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Emabel St Clair</i> ADDRESS <i>1109 Argonne Drive Baltimore</i>		
18. <i>443X</i> <i>151X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <i>Cardiac failure</i> DUE TO <i>Hypertension and arterio-sclerotic Cardiovascular disease</i> (B) <i>Carcinoma of stomach</i> (C) <i>—</i>		
19A. DATE OF OPERATION <i>—</i>			19B. MAJOR FINDINGS OF OPERATION <i>—</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>—</i>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>—</i>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>—</i>	
22. I hereby certify that I attended the deceased from <i>Nov. 1946</i> to <i>19 Oct. 1950</i> , that I last saw the deceased alive on <i>18 Oct. 1950</i> , and that death occurred at <i>4:15 p.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>A. Allan Spier</i>		23B. ADDRESS <i>1134 E. Belvedere Ave.</i>		23C. DATE SIGNED <i>19 Oct 50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Oct 23 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>	
24D. LOCATION (City, town, or county) <i>Baltimore Md.</i>		24E. LOCATION (State) <i>Md.</i>		24F. LOCATION (Country) <i>—</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>OCT 20 1950</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>		25. FUNERAL DIRECTOR <i>Martin &amp; Sons</i> ADDRESS <i>46 B md.</i>	



430  
50 8968FELT,  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8968  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Jacob Felt

2. DATE  
OF  
DEATH

Oct. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JONES HOPKINS HOSPITAL

4. USUAL RESIDENCE

Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give  
township)

D. STREET ADDRESS (If rural, give location)

837 4th St

5. SEX

6. COLOR OR RACE

male white

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

retired

13. FATHER'S NAME

Joseph Felt

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

7-8-00

9. AGE (In years  
last birthday)

50

11. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Edith Dretton

17. INFORMANT

JONES HOPKINS HOSPITAL

ADDRESS

18. 572.2

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Uremia

DUE TO

7 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Nephrosis

DUE TO

(C) Chr. Ulcerative Colitis

?

10 yr.

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/29/50, 1950, to 10/19/50, 1950, that I last saw the  
deceased alive on 10/19/50, 1950, and that death occurred at 14-20m from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

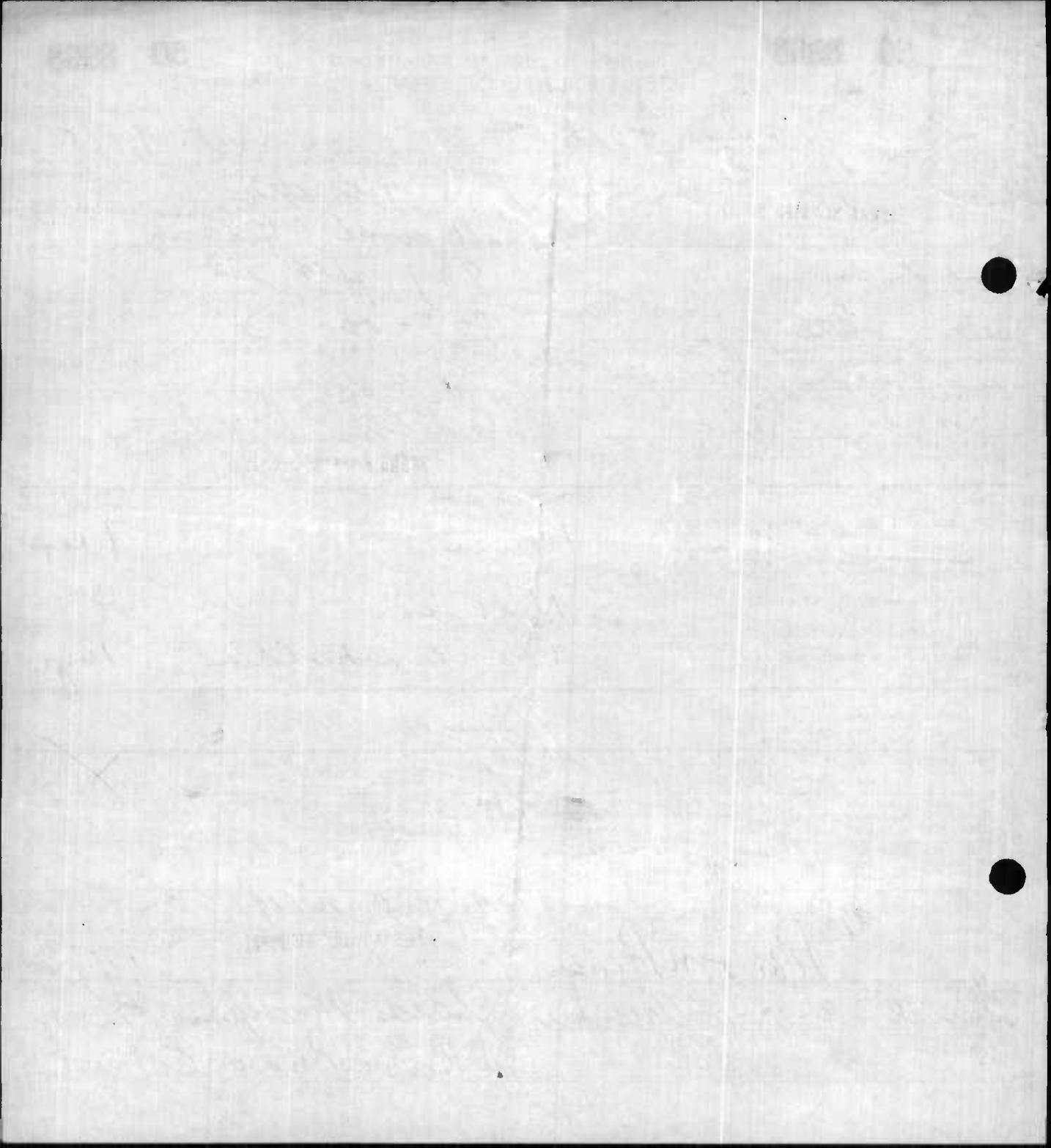
25. FUNERAL DIRECTOR

ADDRESS

VS 150

2906A

1206



520  
50 8969BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8969  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>SIMON RING</b>		2. DATE OF DEATH <b>10-19-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>3706 Mortoma Rd</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>13-01</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>The Mount</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>806 Whitelock St</b>		E. LENGTH OF STAY IN BALTIMORE <b>65</b> Yrs. <b>65</b> Mos. <b>65</b> Days	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>7/1</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Tinsmith SELF</b>	11. BIRTHPLACE (State or foreign country) <b>Austria</b>
13. FATHER'S NAME <b>Morton</b>		14. MOTHER'S MAIDEN NAME <b>Setel</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Albert Ring - Same</b>
18. <b>442X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>10 hours</b> <b>Degenerative Cardio-Vascular</b> <b>Renal Disease</b>		12. CITIZEN OF WHAT COUNTRY? <b>Austria</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 1950</b> to <b>10-19-1950</b> that I last saw the deceased alive on <b>10-19-1950</b> and that death occurred at <b>7:20 p.m.</b> from the causes and on the date stated above.			
23A. SIGNATURE <b>A.A. Jnooner</b>		23B. ADDRESS <b>1107 N. Calver St</b>	23C. DATE SIGNED <b>10-20-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-20-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mishkova Israel</b>	24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 20 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, Md</b>	25. FUNERAL DIRECTOR <b>Jack Leonard</b>	ADDRESS <b>2100 Eutaw Rd</b>

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

59184

1312

Sumner  
Mo 5138

1213 01

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The" and "to" are visible.]*



200  
50 8970BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8970

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

George W. Bish

2. DATE  
OF  
DEATH Oct. 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 5609 Fair Oaks Ave.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5609 Fair Oaks Ave.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

June 5, 1885

9. AGE (in years  
last birthday)

65

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Wholesale baker Ret.

10B. KIND OF BUSINESS OR INDUSTRY

Baking

11. BIRTHPLACE (State or foreign country)

Carroll Co. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Simon P. Bish

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL  
SECURITY NO.

--

17. INFORMANT

ADDRESS

Mrs. Theresa Bish 5609 Fair Oaks Ave.

18. 422.2

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/11/49, 19, to 10/18, 1950, that I last saw the deceased alive on 10/18, 1950, and that death occurred at 11:00 AM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

10/21/ 50

Parkwood

Parkville, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

0661-281350

Huntington Williams, Jr.

Ulrich Funeral Home 2008 Orleans St.

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530 50 8971

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8971

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARIE ERNESTINE SMITH

2. DATE  
OF  
DEATH

10-19-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

UNION MEMORIAL HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND

B. COUNTY BALTIMORE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

TOWSON

5300

D. STREET ADDRESS (If rural, give location)

123 W. SUSQUEHANNA AVE

Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

SEP

8. DATE OF BIRTH

10-19-1894

9. AGE (In years  
last birthday)

75

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR  
INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM B STARKLOFF

14. MOTHER'S MAIDEN NAME

LOUISE STEHL

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. JAMES VAUGHAN - TOWSON, MD.

18. 151X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

CARCINOMA OF STOMACH WITH  
METASTASES

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

CHOLELITHIASIS

19A. DATE OF OPERATION

9-30-50

19B. MAJOR FINDINGS OF OPERATION

CA. OF STOMACH WITH METASTASES, CHOLELITHIASIS

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from SEPT 27, 1950, to OCT 19, 1950, that I last saw the  
deceased alive on 10-19-50, and that death occurred at 12:40 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Richard Beach

M. D.

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

10-19-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

OCT. 21, 1950

24C. NAME OF CEMETERY OR CREMATORY

LONDON PARK CEMETERY BALTIMORE, M. D.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

JOHN BURNS' SONS, TOWSON, MD.

THE STATE OF NEW YORK  
IN SENATE  
JANUARY 10, 1910  
REPORT  
OF THE  
COMMISSIONERS OF THE  
LAND OFFICE  
IN RESPONSE TO  
RESOLUTION PASSED  
JUNE 1, 1909

ALBANY:  
J. B. LEECH, JR.,  
PRINTERS  
1910

RECEIVED  
JAN 15 1910  
OFFICE OF THE  
COMMISSIONER OF THE  
LAND OFFICE

50 8972

BALTIMORE CITY HEALTH DEPARTMENT

50 8972

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

MRS HANNAH PALMBAUM

1. NAME OF DECEASED  
(Type or Print)

Mrs Hannah Palmbaum

2. DATE  
OF  
DEATH

10-19-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Sevindale

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Sevindale

4. USUAL RESIDENCE, (Where deceased lived, If institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

Sevindale

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balt. Md 27-17

C. Length of stay in Baltimore

30 yrs.

Yrs.  
Mos.  
Days

5. SEX

Female White

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Sept 8, 1874

9. AGE (In years,

last birthday)

76

10. Under 1 Year

11. Under 24 Hours

Months: Days: Hours: Min.

8 10

10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)

Housekeeper

10B. KIND OF BUSINESS OR INDUSTRY

Hotel

13. FATHER'S NAME

Isaac Stiefel

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Gerta Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Bessie Palmbaum

ADDRESS

Sevindale

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute pulmonary edema

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive cardiovascular disease

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-3-1949, to 10-19-1950, that I last saw the deceased alive on 10-18-1950, and that death occurred at 12:00 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Jerome J. Blumberg

M. D.

23B. ADDRESS

Sevindale Home

23C. DATE SIGNED

10-19-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

10/22/50

24C. NAME OF CEMETERY OR CREMATORY

BALTO HEBREW CEM

24D. LOCATION (City, town, or county)

BELAIR RD

(State)

DATE RECEIVED BY LOCAL REGISTRAR

OCT 20 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

J. O. Whorner Co

ADDRESS

243 V Reisterstown Rd  
093d 17

STORY 43

THE  
CITY  
OF  
NEW  
YORK





50 8973

CONSTANTINE - OPOLKO  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8973

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

OPOLKO, CONSTANTINE

2. DATE  
OF  
DEATH

October 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

South Baltimore Gen. Hosp.

Yrs.  
Mos.  
Days

Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

Railroad

13. FATHER'S NAME

Justin Opolko

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

215-03-1270

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

23-01

D. STREET ADDRESS (If rural, give location)

917 S. Hanover Street

8. DATE OF BIRTH

6/15/1884

9. AGE (In years  
last birthday)

66

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

M. Prokurot

17. INFORMANT

ADDRESS

Frank Opolko 3551 Juneway

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

5 days

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Myocardial infarction  
Coronary thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Arteriosclerosis

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 14, 1950, to Oct. 19, 1950, that I last saw the deceased alive on Oct. 19, 1950, and that death occurred at 12:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Martin C. Marynjanen

M. D.

23B. ADDRESS

So. Balto. Gen. Hosp.

23C. DATE SIGNED

Oct. 19, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 20 1950

Wilmington, Delaware

J. G. Trebilcock, Jr. 1905 E. Pratt St

VS 150

97050

094a

MEDICAL CERTIFICATION

Correct age is especially important. In infants, please write the causes of death clearly and legibly.

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201 5073

1884 66

Willems

Willems

215-03-1213 with Op. 3221

—

215-03-1213 with Op. 3221  
Willems

655  
50 8974BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8974

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FRANK

(HARMON) Harman

(EMW)

2. DATE  
OF  
DEATH

Oct. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1410 Rosedale St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDDED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 10, 1892

9. AGE (In years,

last birthday)

58

10 Under 1 Year

Months Days

11 Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Stationery Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Western Elec. Co

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Harman

14. MOTHER'S MAIDEN NAME

Jennie Kirkland

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W. 1

16. SOCIAL SECURITY NO.

216-03-2865

17. INFORMANT

ADDRESS

Mrs. Elizabeth Harman 1410 Rosedale St

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. Fisher

23B. CHIEF MEDICAL EXAMINER..... ☐M.D. MEDICAL INVESTIGATOR..... ☐

23C. DATE SIGNED

Oct. 19, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-23-1950

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore,

Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

G. Howard Strong 3207 W. North Ave.



260 50 8975

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8975

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Clara A. Tucker

2. DATE  
OF  
DEATH

October 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)  
A. STATE B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

2123 Wilhelm Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

20-05

D. STREET ADDRESS (If rural, give location)

2123 Wilhelm Street

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 5, 1876

9. AGE (in years;  
last birthday)

74

If Under 1 Year If Under 24 Hours  
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Hiriam Comer

14. MOTHER'S MAIDEN NAME

Arthelia Turner

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Gertrude Friedman, 1822 Wilkens Ave.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Metastatic carcinoma,  
left mandibular tonsillar region  
(squamous cell)

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

21 Months

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Heart Disease

underlying

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1949 to Oct 19, 1950, that I last saw the  
deceased alive on Oct 19, 1950, and that death occurred at 12 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Nathan Taensin

23B. ADDRESS

M. O.

206 S. Gilman St.

23C. DATE SIGNED

10.20.50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

10/21/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION (City, town, or county)

Baltimore

(State)

Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Armstrong &amp; Co., Inc.

ADDRESS

1217 St. Paul Street

Was there in clinical  
history indication of  
probable primary site  
of carcinoma?

See Document File 50-8975

100-31-50  
ES



520 50 8976

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8976

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BERNARD J. KNOX

2. DATE  
OF  
DEATH

10/19/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

809 Cator Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE  
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

809 Cator Avenue

E. Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

May 27, 1883

9. AGE (In years  
last birthday)

67

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer - unemployed

10B. KIND OF BUSINESS OR  
INDUSTRY

000 Jobs

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Andrew Knox

14. MOTHER'S MAIDEN NAME

Annie Rosenthal

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. M. A. Meyers, 809 Cator Avenue

18. 161 X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an \_\_\_\_\_ thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

John P. Davis

23B. CHIEF MEDICAL EXAMINER..... ☐ASSISTANT MEDICAL EXAMINER..... ☐

23C. DATE SIGNED

10/20/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

10/23/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county) (State)

Baltimore,

Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Antonia M. Williams, M.D.

25. FUNERAL DIRECTOR

St. M. Cook, Inc.

1217 St. Paul Street

VS 151

97099

047 a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



5-512

50 8977

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8977  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)W.  
Amelia SHANEY BROOK2. DATE  
OF  
DEATH

Oct 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

S. Mill Avenue 5300

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Nov 23-1890

9. AGE (In years  
last birthday)

59

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Baltimore Co. Ind

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Sundiman

14. MOTHER'S MAIDEN NAME

Virginia

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

not

17. INFORMANT

ADDRESS

Charles Edward Shanabrook

18. 600.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Uremia, cause  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Probably chronic  
DUE TO

(C) pyelonephritis

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

I

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-1, 1950, to 10-19, 1959 that I last saw the  
deceased alive on 10-18, 1950, and that death occurred at 12:48 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Elmer W. Danvers M. D.

23B. ADDRESS

University Hosp.

23C. DATE SIGNED

Oct 19, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)Burial  
DATE RECEIVED BY  
LOCAL REGISTRAR

24B. DATE

10/21

24C. NAME OF CEMETERY OR CREMATORY

Dundalk Heights

24D. LOCATION (City, town, or county)

Pikesville Ind

(State)

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

Frank H. Newell Pikesville Ind

ADDRESS

OCT 20 1950

133a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 8877

50 8877

H-510  
50 8978BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8978  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Leonardis M Lagenby

2. DATE  
OF  
DEATH

Oct 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

A. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Md 25-42

D. STREET ADDRESS (If rural, give location)

3216 Hollins Ferry Rd

E. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years last birthday)

Under 1 Year  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 198.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Petroperitoneal Sarcoma, 7mo

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic Cor Pulmonale, 10mo

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNOER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 9/25/1950, to 10/18/1950, that I last saw the deceased alive on 10/18/1950, and that death occurred at 728 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

David Liebens M. D.

JOHNS HOPKINS HOSPITAL

10-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 20 1950

Washington Williams M.D.

Edward Toulson 2353 Wash Blvd

Baltimore Md

97052

046h





B-260  
50 8979BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8979  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Charles T. Baker</u>			2. DATE OF DEATH <u>10/18/50</u>		
3. PLACE OF DEATH: A. <u>Baltimore City, Maryland</u> <u>Baltimore, Maryland</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>25-43</u>		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <u>1910 Breitwert Avenue.</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12/10</u>	9. AGE (In years last birthday) <u>74</u>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>			11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		
13. FATHER'S NAME <u>William Baker</u>			14. MOTHER'S MAIDEN NAME <u>Elsie Jones</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		

18. <u>540.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) <u>Subdaphragmatic Abscess</u> DUE TO (B) <u>Perforation of Stomach</u> DUE TO (C) <u>Chronic Ulceration Lesser Curvature of Stomach</u>	INTERVAL BETWEEN ONSET AND DEATH <u>8 days?</u> <u>15 days?</u> <u>yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <u>10/18/50</u>	19B. MAJOR FINDINGS OF OPERATION <u>Subdaphragmatic Abscess</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <u>No</u>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>—</u>
22. I hereby certify that I attended the deceased from <u>10/16/50</u> , 19 <u>—</u> , to <u>10/18/50</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>10/18/50</u> , 19 <u>—</u> and that death occurred at <u>2:55 P.</u> m., from the causes and on the date stated above.		
23A. SIGNATURE <u>Wm. B. Sullivan</u>	23B. ADDRESS <u>1213 Light Street</u>	23C. DATE SIGNED <u>10/18/50</u>

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10-21-50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>St. Oliver's</u>	24D. LOCATION (City, town, or county) (State) <u>Frederick Rd</u>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <u>William B. Sullivan</u>	25. FUNERAL DIRECTOR <u>Edward J. Sullivan</u>	ADDRESS <u>2359 Loach Blvd</u> <u>Baltimore Md</u>

OCT 21 1950

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 8980  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>GEORGE M. BLANCHARD</b>			2. DATE OF DEATH <b>October 18, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>University Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>12-06</b>		
D. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			E. STREET ADDRESS (If rural, give location) <b>265 W. 31st Street</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Dec. 29, 1885</b>		9. AGE (In years last birthday) <b>64</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Dept</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? _____
13. FATHER'S NAME <b>William S. Blanchard</b>			14. MOTHER'S MAIDEN NAME <b>Sarah E. Meredith</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	17. INFORMANT ADDRESS <b>Mr. Charles E. Van Fleet 1816 Dukeland S</b>		

18. **420.1**

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH \_\_\_\_\_

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Myocardial infarct**  
DUE TO **coronary artery sclerosis**

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_  
DUE TO \_\_\_\_\_  
(C) \_\_\_\_\_

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION _____		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>Stanley B. Dunleavy</i> M.D.		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> MEDICAL ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		23C. DATE SIGNED <b>Oct. 19, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/21/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Wash., D. C.</b>	

DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 20 1950</b>	REGISTRAR'S SIGNATURE <i>William M. ...</i>	25. FUNERAL DIRECTOR <i>Wm. J. ...</i>	ADDRESS <i>94a ...</i>
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correct age is especially important. In all cases, please write the causes of death clearly and fully.



C-654  
50 8981BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8981

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>ANNIE CROMWELL</b>		2. DATE OF DEATH <b>Oct. 19, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>613 E. 32nd St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>613 E. 32nd St.</b>		9-05	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>Feb. 8, 1869</b>	
9. AGE (In years last birthday) <b>81</b>		10. Under 1 Year Months: _____ Days: _____	
11. Under 24 Hours Hours: _____ Min: _____		12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>	
13. FATHER'S NAME <b>Paul Heimiller</b>		14. MOTHER'S MAIDEN NAME <b>Schnauffer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Mr. Walter P. Cromwell</b>		ADDRESS <b>613 E. 32nd St.</b>	

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Sclerosis</b> DUE TO <b>Generalized arteriosclerosis</b> DUE TO <b>age</b> DUE TO <b>diabetes mellitus</b>	INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>5 yrs.</b> <b>3 yrs.</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>Oct. 19, 1950</b>	19B. MAJOR FINDINGS OF OPERATION <b>Coronary Sclerosis</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **October 19, 1949** to **Oct. 19, 1950**, that I last saw the deceased alive on **Oct. 18, 1950**, and that death occurred at **6 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE <b>M. B. Schreiber</b>	23B. ADDRESS <b>54 S. Fulton Ave.</b>	23C. DATE SIGNED <b>10-20-50</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10.21.50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
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DATE RECEIVED BY LOCAL REGISTRAR <b>Oct 20 1950</b>	REGISTRAR'S SIGNATURE <b>Wm. J. Dickner &amp; Sons - Balto</b>	25. FUNERAL DIRECTOR <b>Wm. J. Dickner &amp; Sons - Balto</b>	ADDRESS <b>061.0 md.</b>
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1898 01

1898 02





G-625  
50 8982BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8982  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		BERTHA PEARL GROSHON		2. DATE OF DEATH Oct. 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 2907 Brighton St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 16-07			
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 2907 Brighton St.			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Sept. 15, 1891	9. AGE (In years last birthday) 59	H Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES Clerk		10B. KIND OF BUSINESS OR INDUSTRY Ice Cream (R)		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William Whalen			
14. MOTHER'S MAIDEN NAME Nettie Bowers		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Louis F. Groshan - 2907 Brighton St.			

18. 170X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Scirrhous Carcinoma - Breast (B) General Metastasis (C)		INTERVAL BETWEEN ONSET AND DEATH 7 yrs. 1 1/2 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 1943		19B. MAJOR FINDINGS OF OPERATION Carcinoma of left breast.		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from ap, 1948, to Oc, 1950, that I last saw the deceased alive on Oc 19, 1950, and that death occurred at 5:13 P. m., from the causes and on the date stated above.					
23A. SIGNATURE Harold H Burns		23B. ADDRESS M. D. 529 N. Charles St		23C. DATE SIGNED Oct 20, 1950	

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/23/50		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		24D. LOCATION (City, town, or county) (State) Woodlawn, Md.	
DATE RECEIVED BY LOCAL REGISTRAR OCT 20 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR [Signature]		ADDRESS Baltimore Md.	

VS 150

4906B

050.0

MEDICAL CERTIFICATION

correct age is especially important in young persons

3328 86

3303 86

P-625  
50 8983BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8983

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Katherine Puchniewski

2. DATE  
OF  
DEATH

Oct 18 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore Md

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street address or location)

506 S. Rose St.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

1-02

D. STREET ADDRESS (If rural, give location)

506 S. Rose St.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Thomas Skibinski

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 420.1  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from 10/10, 1950, to 10/18, 1950, that I last saw the  
deceased alive on 10/18, 1950, and that death occurred at 1:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 20 1950

Burial Oct 21 1950 St. Stanislaus Dundalk Ave Md.  
John J. Bluda Inc 2829 Hudson St

093d

3003 86

HYA50 82 45 1975

3003 86

31 5 A

M-530  
REA-142397

50 8984

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

50 8984

1. NAME OF DECEASED  
(Type or Print)

August Monte

2. DATE  
OF  
DEATH

October 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE Baltimore City Hospitals

4940 Eastern Avenue

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

27 N. Carey St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

May 30, 1880

9. AGE (In years,  
last birthday)

70

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

CEMENT FINISHER

10B. KIND OF BUSINESS OR  
INDUSTRY

C. N. J. T.

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

212-01-9117

17. INFORMANT

ADDRESS

Reocdrs: B. C. H. 4940 Eastern Avenue

18. 156.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Carcinoma of Liver

DUE TO

Unknown

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Heart Disease with failure years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-10, 1950 to 10-18, 1950 that I last saw the  
deceased alive on 10-18, 1950, and that death occurred at 8:25 Pm., from the causes and on the date stated above.

23A. SIGNATURE

*H. J. J. J.*

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Oct 21-1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem.

24D. LOCATION (City, town, or county)

4430 Belair Rd

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*William H. Williams, M.D.*

25. FUNERAL DIRECTOR

ADDRESS

Frank Geller Woe 322 S. High St

50 8884

MENTAL HEALTH INSTITUTE  
CENTRAL OF DEATH

50 8884

111-10-111

111-10-111  
111-10-111



B-4 304 8985

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8985  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Elizabeth Lizzie Blackwell

2. DATE  
OF  
DEATH

10-19-50

3. PLACE OF DEATH

A. Baltimore City, Maryland

Baltimore

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

1111 Warner Street

38

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

21-01

D. STREET ADDRESS (If rural, give location)

1111 Warner Street

Length of stay in Baltimore

SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

4-15-1899

9. AGE (In years last birthday)

51

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Home wife

11. BIRTHPLACE (State or foreign country)

Potsmouth Va

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Gasper Butt

14. MOTHER'S MAIDEN NAME

Clara Berans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Solomon Blackwell 1111 Warner Street

18. 442X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Respiratory Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Arteriosclerosis + hypertension  
Cardio vascular renal disease

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from June 1949 to Oct 19, 1950, that I last saw the deceased alive on Oct 18, 1950 and that death occurred at 330 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

J. Howard Lohy M.D.

M.D.

601 N Howard St

10/19/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

10-23-1950

Mount Auburn Cemetery Baltimore City

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 20 1950

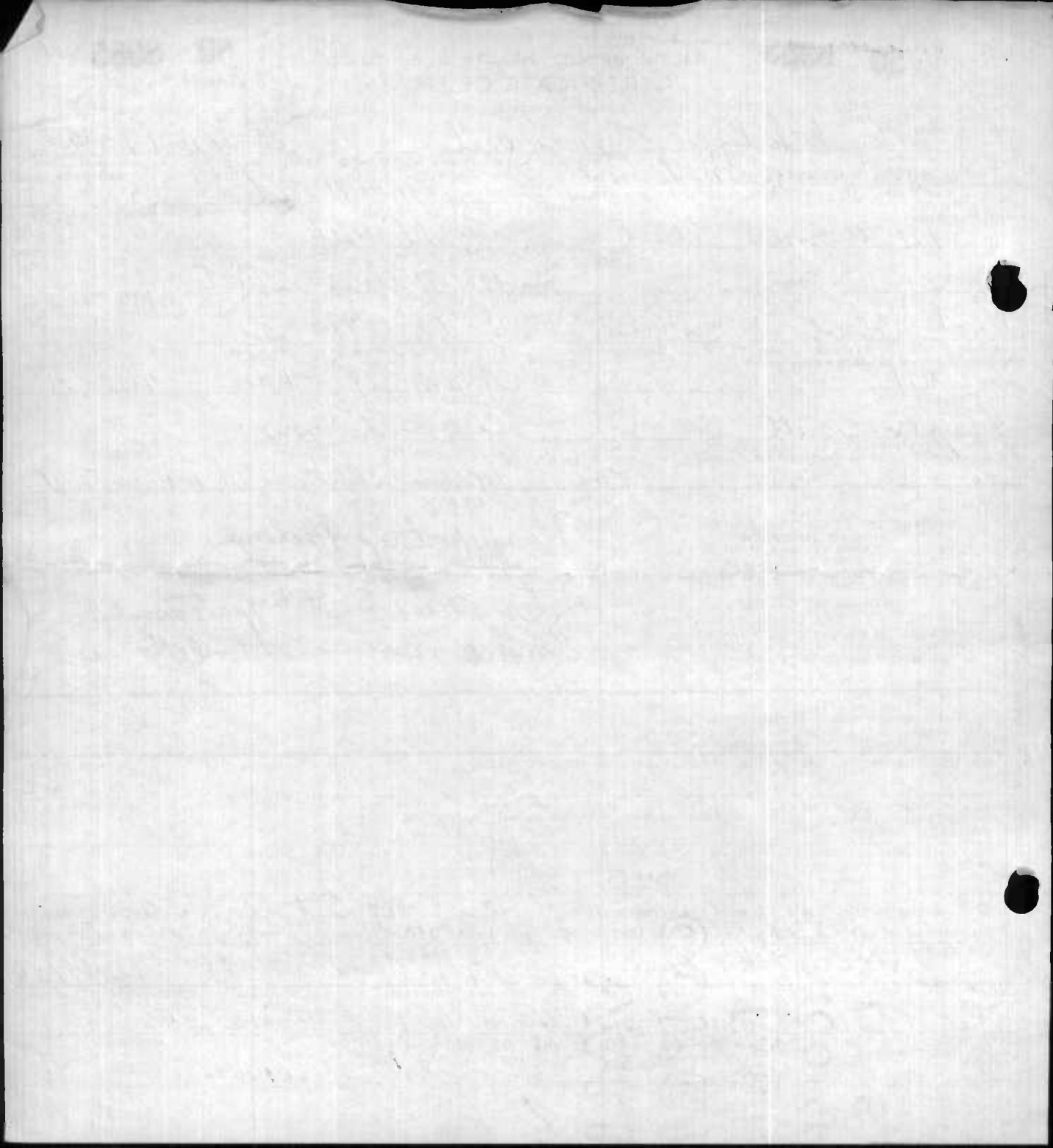
J. Howard Lohy M.D.

Joseph L. Lohy 661 West Bane St

VS 150

131a

MEDICAL CERTIFICATION



V-2550 8986

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8986  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ALICE V. VAUGHAN

2. DATE  
OF  
DEATH

Oct. 20-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1005 S PACA ST.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

FEM.

6. COLOR OR RACE

WHT.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOW.

8. DATE OF BIRTH

DEC-29-1875

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOUSE WORK.

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

JACOB. FRYERLY.

11. BIRTHPLACE (State or foreign country)

BALTIMORE MD

12. CITIZEN OF  
WHAT COUNTRY?

US

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

DOLORES. JETT-1005 S PACA ST.

18. 151X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Carcinoma of Stomach

1 yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Arterio sclerosis

?

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

Carcinomatosis

?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office, etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK NOT WHILE AT WORK

22. I hereby certify that I attended the deceased from July, 1950, to Oct 20, 1950, that I last saw the  
deceased alive on 10/10, 1950, and that death occurred at 6.45 PM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

201950

VS 150

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MEDICAL CERTIFICATION

correct age is especially important

8888

02

THE UNIVERSITY OF CHICAGO  
CHICAGO, ILLINOIS 60637

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## BALTIMORE CITY HEALTH DEPARTMENT

50 8987  
Registered No.BIRTH NO. 50 8987 00-20088  
CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print) O'DELL CARMICHAEL		2. DATE OF DEATH October 18, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland b. COUNTY	
b. FULL NAME OF (If not in hospital or institution, give street address or location) University Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-07	
length of stay in Baltimore		d. STREET ADDRESS (If rural, give location) 115 W. 23rd Street	
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Sept. 1950
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 1	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Odell Carmichael Sr.		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Ernestine Johnson.	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Odell Carmichael Sr. 115 W. 23rd St.	

18. E983X 1 E 460 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 1476 147 days DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) Fracture skull DUE TO (B) Subdural hematoma, bilateral DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 115 W. 23rd Street 12/7		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY October 19, 1950 4-6p.m.	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? fell to concrete floor while being swung around the room		
22. I certify that I took charge of the remains described above, held an <u>autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .				
23A. SIGNATURE Stanley H. Dureacher		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Oct. 19, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 10-20-1950	24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Balto.	24d. LOCATION (City, town, or county) (State) Md.	
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR Mrs. Fabio R. Williams N. Schrodin		

VS 151 01950

N 803.20

195c

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

8888 02

The Toledo changed rate

E 983 x to 926.0

8888 02



243659  
B-50050 8988

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8988  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Melvin Bane</i>			2. DATE OF DEATH <i>Oct 16, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Med. Csl 2</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>14-02</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>JONES HOPKINS HOSPITAL</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
Length of stay in Baltimore <i>28 yrs</i>			D. STREET ADDRESS (If rural, give location) <i>1418 Druid Hill ave</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>sep</i>	8. DATE OF BIRTH <i>1-24-1909</i>		9. AGE (In years last birthday) <i>41</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>mechanic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Auto mobile</i>	11. BIRTHPLACE (State or foreign country) <i>Durham County N.C</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>James Bane</i>			14. MOTHER'S MAIDEN NAME <i>Osa Baughman</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-01-8470</i>		17. INFORMANT <i>JONES HOPKINS HOSPITAL</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>			ADDRESS		

18. <i>022X</i>		CAUSE OF DEATH <i>(Hemorrhage)</i>		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Rupture into left pleural cavity</i>		<i>24 hrs.</i>	
ANTECEDENT CAUSES		(B) <i>Aneurysm of aorta</i>		<i>3 yrs.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)			

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION <i>2</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *10-15-*, 19*50* to *10-16-*, 19*50*, that I last saw the deceased alive on *10-16-*, 19*50*, and that death occurred at *3:20 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Victor G. McKusick</i> M. D.		23B. ADDRESS <i>JONES HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>10/17/50</i>	
---	--	---	--	-------------------------------------	--

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/19/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltob Md</i>	
--	--	------------------------------	--	--	--	---	--

DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>William D. Williams</i>		25. FUNERAL DIRECTOR <i>Charles H. H. H.</i>		ADDRESS <i>512 N Carrollton</i>	
----------------------------------	--	---	--	---	--	------------------------------------	--

OCT 20 1950

55083

030d

correct age is especially important

Was aneurysm of aorta  
syphilitic in origin?  
yes!

See Document File 50-8988

10-31-50  
20

BIRTH NO. 50 8989

1. NAME OF DECEASED (Type or Print)		DAVID		BALL		2. DATE OF DEATH October 19, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) a. STATE Maryland b. COUNTY			
5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) Maryland General Hospital Length of stay in Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-01			
d. STREET ADDRESS (If rural, give location) 1359 N. Gilmor Street				e. DATE OF BIRTH April 18, 1869			
6. SEX Male		6. COLOR OR RACE Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower		9. AGE (In years last birthday) 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Taylor Ball				14. MOTHER'S MAIDEN NAME Julia			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mildred Ball Coleman		ADDRESS 1022 N. Wolfe St.	

18. <u>443X</u>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <u>Hypertensive cardiovascular disease</u> DUE TO	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) _____ DUE TO  (C) _____	
II OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>Stanley K. Denecker</i>		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>10-20-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <b>10/23/50</b>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn</i>	24D. LOCATION (City, town, or county) (State) <i>Westport, Balto. Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <b>10-20-1950</b>	REGISTRAR'S SIGNATURE <i>Thurston Williams</i>		25. FUNERAL DIRECTOR ADDRESS <i>Metropolitan Funeral Home, Inc.</i>	

927. n. minut. St  
093d

CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

1. Name of deceased  
2. Sex  
3. Race  
4. Date of birth  
5. Date of death  
6. Place of death  
7. Cause of death  
8. Manner of death  
9. Signature of physician  
10. Signature of registrar

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 8990  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Edward W. Johnson

2. DATE  
OF  
DEATH

10/18/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, City

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

907 Warmer Street

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore, City.

D. STREET ADDRESS (If rural, give location)

907 Warmer Street

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

5/20/ 1899

9. AGE (In years last birthday)

51

10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

Coal Company

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John H. Johnson

14. MOTHER'S MAIDEN NAME

Laura V. Murdock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Margaret Johnson-907 Warmer, Street.

18. 334X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral sclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Hypertension + generalized arteriosclerosis

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Rheumatic arthritis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Sept 14, 1950 to Oct 18, 1950, that I last saw the deceased alive on Oct 14, 1950, and that death occurred at 8 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/21/50

24C. NAME OF CEMETERY OR CREMATORY

Asbury Cemetery

24D. LOCATION (City, town, or county)

Town Neck, Maryland

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

10822  
L. Brown + Son - Montgomery

OCT 20 1950

683 6T

087d

MEDICAL CERTIFICATION

correct age is especially important. Physicians: Please print name and address.

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W-355 8991

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 8991

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Minnie C. Weidenhammer

2. DATE  
OF  
DEATH

Oct. 19/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION 330 S. Stricker St.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Md.  
B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 19-03D. STREET ADDRESS (If rural, give location)  
330 S. Stricker St.Length of stay in Baltimore  
Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Jan 9 1880

9. AGE (in years  
last birthday)

70

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Edward Weidenhammer

14. MOTHER'S MAIDEN NAME

Mary Weidenhammer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Henrietta Weidenhammer, 330 S. Stricker St.

18. 442X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

CERTIFICATION BY  
DR. JOHN R. DAVIS

CHIEF OR ASST. MEDICAL EXAMINER

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

none

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/1, 1949 to 10/19/1950 that I last saw the  
deceased alive on 10/19, 1950 and that death occurred at 12:44 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OCT 20 1950

Huntington Williams

Harry H. Witzke

4101 Edmondson Ave.

1312

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1908 08

1908 08 01

1908 08 02

1908 08 03

1908 08 04

1908 08 05

C-234  
50 8992BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8992

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas Costello

2. DATE  
OF  
DEATH

October 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

UNIVERSITY HOSPITAL

Length of stay in Baltimore

55 yrs

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

28-04

D. STREET ADDRESS (If rural, give location)

7 Mallow Hill

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Furniture designer

10B. KIND OF BUSINESS OR INDUSTRY

Schaffner Furnish Co.

13. FATHER'S NAME

Castello

8. DATE OF BIRTH

Jan. 18, 1871

9. AGE (In years last birthday)

79

11 Under 1 Year Months Days

11 Under 24 Hours Hours Min.

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Chas. T. Castello, 7 Mallow Hill Md.

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Broncho pneumonia

3 days

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Fracture Pubic Ram.

13 days

DUE TO

(C)

Arterio-Sclerotic Cardio-Vascular Disease

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

## CERTIFICATION APPROVED BY

Sensitivity Stanley K. Henderson

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? ☒ YES ☐ NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

7 Mallow Hill

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

Oct. 5, 1950

m.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Patient Fell to floor

22. I hereby certify that I attended the deceased from 10/5, 1950 to 10/18, 1950, that I last saw the deceased alive on 10/18, 1950, and that death occurred at 4:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Charles T. Henderson

M. D.

23B. ADDRESS

UNIVERSITY HOSPITAL

23C. DATE SIGNED

10/18/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Oct. 23/50.

24C. NAME OF CEMETERY OR CREMATORY

London Pl. 3801 Frederick St. Balt. Md.

24D. LOCATION (City, town, or county)

(State)

REGISTRAR'S SIGNATURE

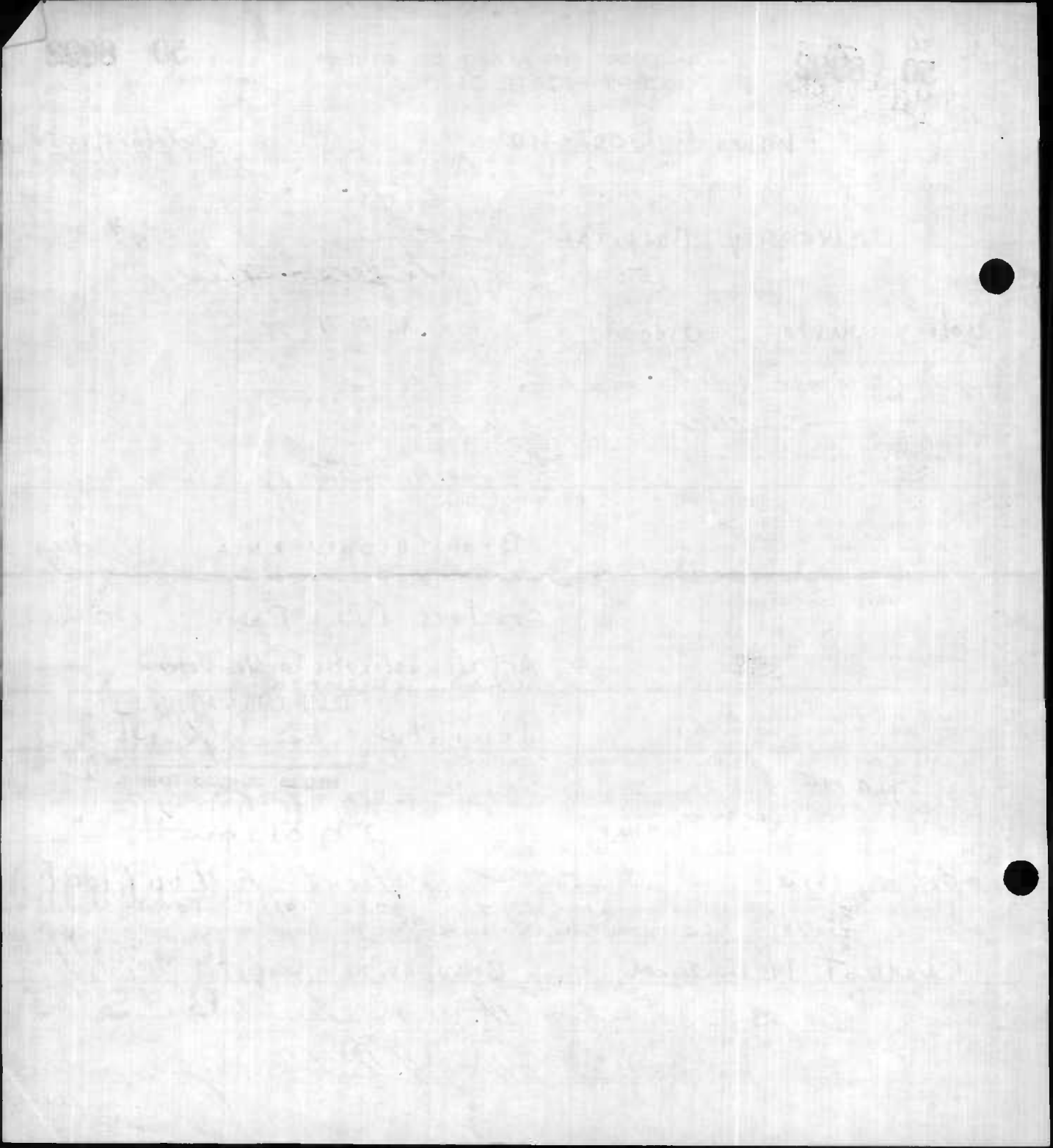
T. W. Williams, Jr.

25. FUNERAL DIRECTOR

Harry H. Witzke, 4101 Edmondson

ADDRESS

186 a Ave.



D-220

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 8993

BIRTH NO.

50 8993

1. NAME OF DECEASED  
(Type or Print)

ARTHUR S. DICUS

2. DATE  
OF  
DEATH

10-19-50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

36 Franklin Square Hospital

Yrs.  
Mos.  
Days

length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

10-8-1876

9. AGE (In years  
last birthday)

74

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Huckster HUCKSTER

10B. KIND OF BUSINESS OR  
INDUSTRY

none

13. FATHER'S NAME

John Dicus

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

American

14. MOTHER'S MAIDEN NAME

Susan Watts

17. INFORMANT

ADDRESS

Mrs. Maggie Dicus

18. 141X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Coronary Occlusion

5 minutes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

Carcinoma, tongue

6 months

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

9-29-50

19B. MAJOR FINDINGS OF OPERATION

Carcinoma base of tongue, right

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 8, 1950, to Oct. 19, 1950, that I last saw the  
deceased alive on Oct 19, 1950, and that death occurred at 9:15 p. m., from the causes and on the date stated above.

23A. SIGNATURE

M. Lindelorn

M. O.

23B. ADDRESS

Franklin Sq. Hosp.

23C. DATE SIGNED

10/19/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Oct 23

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

Baltimore

(State)

MD

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

Harry T. Kiefer 4101 Edmonson

OCT 20 1950

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

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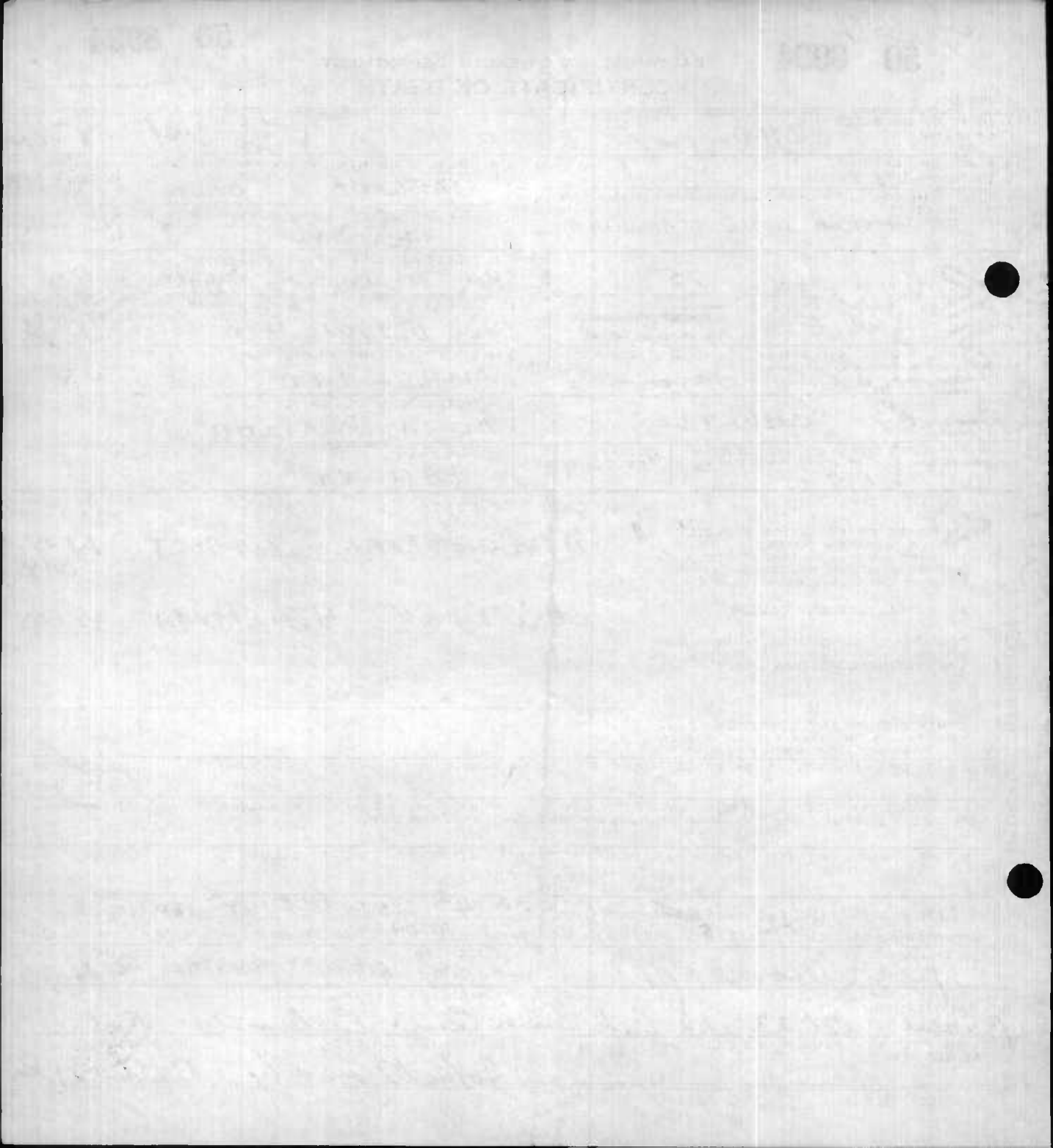
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 50 8994	
BIRTH NO. 450 8994				2. DATE OF DEATH Oct. 19 <sup>th</sup> 1950	
1. NAME OF DECEASED (Type or Print) SCHULTZE OTTO					
3. PLACE OF DEATH: A. Baltimore City, Maryland ✓				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RURAL 5300	
Length of stay in Baltimore 15 Yrs. Mos. Days				D. STREET ADDRESS (If rural, give location) Box 180 Bowleys Quarters Rd	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Feb 11 <sup>th</sup> 1901	9. AGE (In years last birthday) 49	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME EARNEST SCHULTZE			14. MOTHER'S MAIDEN NAME DORA LAIZOR.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.		
17. INFORMANT PATIENTS			ADDRESS		
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH MYOCARDIAL INFARCT (A) DUE TO CORONARY ATHEROMA (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 14-15 DAYS YEARS					
19A. DATE OF OPERATION 2				19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct 4 <sup>th</sup> , 1950, to Oct 14 <sup>th</sup> , 1950, that I last saw the deceased alive on Oct 19, 1950, and that death occurred at 1020A M., from the causes and on the date stated above.					
23A. SIGNATURE Kirk Mone MD. M. D.		23B. ADDRESS CHURCH HOME & HOSPITAL		23C. DATE SIGNED Oct 15 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 23 - 1950		24C. NAME OF GEMETERY OR CREMATORY Oak Lawn Cem.	
24D. LOCATION (City, town, or county) Eastern Ave. Rd.		24E. FUNERAL DIRECTOR John D. Connelly		24F. ADDRESS Balto. 21, Md.	
DATE RECEIVED BY LOCAL REGISTRAR 001-201950		REGISTRAR'S SIGNATURE		ADDRESS	

MEDICAL CERTIFICATION

10010

094a



5-1200 8995

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8995

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Harry W. Seebach Jr.</i>			2. DATE OF DEATH <i>10-19-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Ind.</i> B. COUNTY <i>Balt.</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Univ. Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balt.</i>		
D. STREET ADDRESS (If rural, give location) <i>1118 S. Poca St.</i>			E. LENGTH OF STAY IN BALTIMORE <i>life</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>single</i>	8. DATE OF BIRTH <i>Sept 28, 1938</i>	9. AGE (in years last birthday) <i>12</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>		
11. BIRTHPLACE (State or foreign country) <i>Ind.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Harry Seebach Sr.</i>			14. MOTHER'S MAIDEN NAME <i>Mary D. Skimmedes</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>none</i>		
17. INFORMANT <i>Father - Harry W.</i>			ADDRESS <i>1118 S. Poca St.</i>		

18. <i>201X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Suffocation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Hodgkins</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>10-19-50</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>10-1-50</i> , 19 <i>50</i> , to <i>10-19-50</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>10-19-50</i> , 19 <i>50</i> , and that death occurred at <i>5:30</i> m., from the causes and on the date stated above.				
23A. SIGNATURE <i>Wilbur S. Baerman</i>		23B. ADDRESS <i>Univ. Hosp.</i>		23C. DATE SIGNED <i>10-19-50</i>

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>10-23-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Landon Park</i>	24D. LOCATION (City, town, or county) (State) <i>Balt. Ind.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>Oct 20 1950</i>	REGISTRAR'S SIGNATURE <i>Wm. Cask, Inc.</i>	25. FUNERAL DIRECTOR <i>1217 St Paul</i>	

20 8000

20 8000



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 8996  
Registered No.

BIRTH NO.

50 8996

1. NAME OF DECEASED (Type or Print) <b>ANNA YOUNG HAYDEN</b>		2. DATE OF DEATH <b>Oct. 15, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Found at the pier at Eden &amp; Lancaster Sts.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 3-07</b>	
6. LENGTH OF STAY IN BALTIMORE <b>Yrs. Mos. Days</b>		D. STREET ADDRESS (If rural, give location) <b>125 S. HIGH ST.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>	8. DATE OF BIRTH
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SALESLADY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>GEN. (R)</b>	9. AGE (In years last birthday) <b>61</b>
11. BIRTHPLACE (State or foreign country) <b>BOSTON, MASS.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT J. YOUNG</b>		14. MOTHER'S MAIDEN NAME <b>ANN L. BOYLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>ROBERT J. LEIGHTON</b>		ADDRESS <b>1931 Roxbury St. ROXBURY MASS.</b>	

18. <b>E-983 X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Multiple contusions of head</b> DUE TO <b>Subdural hemorrhage</b> <b>(B)</b> DUE TO <b>(C)</b>		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Public</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Found at pier at Eden &amp; Lancaster Sts.</b>		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>? ? m.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Blunt force</b>		
22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .				
23A. SIGNATURE <i>William W. [Signature]</i>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>Oct. 18, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>10-24/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>New Calvary Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Boston, Mass.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>OCT 20 1950</b>		25. FUNERAL DIRECTOR <b>John C. Miller, Inc. 2435 E. Ohio St.</b>		

MEDICAL CERTIFICATION

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*[Faint, mostly illegible text from a document, possibly a letter or report, is visible through the paper. Some words like "Dear Sir" and "Very respectfully" are faintly discernible.]*



H-325  
50 8997BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 8997

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) JENNIE HORNER HIEATZMAN		2. DATE OF DEATH Oct. 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 1806 Eutaw Place		6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-03	
7. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days		8. STREET ADDRESS (If rural, give location) 1806 Eutaw Place	
9. SEX female	10. COLOR OR RACE white	11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	12. DATE OF BIRTH Aug. 28, 1871
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		14. AGE (in years last birthday) 79	
15. FATHER'S NAME Alexander Horner		16. CITIZEN OF WHAT COUNTRY? Maryland	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		18. MOTHER'S MAIDEN NAME ?	
19. SOCIAL SECURITY NO.		20. INFORMANT ADDRESS Mr. Herbert M. Hieatzman - 1806 Eutaw Place	

18. 422.2 I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## CAUSE OF DEATH

(A) *Heart Disease*  
DUE TO  
(B) *Myocardial Degeneration*  
DUE TO  
(C)

INTERVAL BETWEEN  
ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from April 1949, to Oct 19, 1950, that I last saw the deceased alive on Oct 19, 1950, and that death occurred at 11:30 p.m., from the causes and on the date stated above.					
23A. SIGNATURE <i>H. H. Hieatzman</i>		23B. ADDRESS 4310 Liberty Ave M. D.		23C. DATE SIGNED 10/20/50	

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/23/50		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		24D. LOCATION (City, town, or county) (State) Pikesville, Md.	
DATE RECEIVED BY LOCAL REGISTRAR OCT 21 1950		REGISTRAR'S SIGNATURE <i>H. H. Hieatzman</i>		25. FUNERAL DIRECTOR <i>H. H. Hieatzman</i>		ADDRESS Baltimore Md.	

1938

10

1938

10

D-250  
50 8998BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 8998  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Katherine Dixon</i>		2. DATE OF DEATH <i>Oct 19 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>Md</i> B. COUNTY <i>✓</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>803 Cedarcrest Rd</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 27-48</i>	
D. STREET ADDRESS (If rural, give location) <i>803 Cedarcrest Rd</i>		8. DATE OF BIRTH <i>Sept 25 1892</i>	
5. SEX <i>F</i> 6. COLOR OR RACE <i>W.</i> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>		9. AGE (In years, last birthday) <i>58</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Balt. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George A. Stark</i>		14. MOTHER'S MAIDEN NAME <i>Louise E. Holzer</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Thos. F. Dixon</i>		ADDRESS <i>Same</i>	

18. *331X*

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*Cerebral Hemorrhage*

INTERVAL BETWEEN ONSET AND DEATH

*15 hrs -*

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

*arterial hypertension**10 yrs -*

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION *0* 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *1946*, to *Oct 19*, 19*50*, that I last saw the deceased alive on *Oct 19*, 19*50*, and that death occurred at *8:50 p.m.*, from the causes and on the date stated above.

23. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Dr. Thos L. Worsley Jr  
2900 Alameda Blvd

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 8999  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

VICTOR A. PYLES SR.

2. DATE  
OF  
DEATH

10/19/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 4017 Fourth Street

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Md.  
B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 25-04

D. STREET ADDRESS (If rural, give location)  
4017 Fourth Street

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

1/24/1885

9. AGE (In years  
last birthday)

65

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Contractor

10B. KIND OF BUSINESS OR  
INDUSTRY

Self (CONST.)

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Joseph H.

14. MOTHER'S MAIDEN NAME

Mary T. Creamer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

Yes

WW I & 2

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Family - Same

ADDRESS

18. 420.1 I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Myocardial degeneration

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Coronary artery disease

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office building, etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from March 20, 1950, to Oct 19, 1950 that I last saw the deceased alive on Oct 18, 1950 and that death occurred at 8-20 AM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

B

24B. DATE

10/23/50

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cem.

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

21 1950

VS 150

- 130 E. Fort Ave.

29024

093d

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9008 05



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 9000  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>STEVE JAIMEDES</b>		2. DATE OF DEATH <b>October 20, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>D.C.</b> B. COUNTY <b>V-48</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>US Marine Hospital Wyman Pk. Drive &amp; 31st St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Washington,</b>	
Length of stay in Baltimore <b>66 days</b> Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>3504 Minnesota Avenue, SE</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>8/15/89</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Master</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Seafarer</b>	9. AGE (In years last birthday) <b>61</b>
13. FATHER'S NAME <b>Nicholas Jaimeodes</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>?</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>?</b>	
11. BIRTHPLACE (State or foreign country) <b>Greece</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
17. INFORMANT <b>Records- US Marine Hospital</b>		ADDRESS	

18. <b>162X</b> <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchogenic carcinoma left lung</b> (A) _____ DUE TO _____ ANTECEDENT CAUSES <b>Bronchopneumonia</b> (B) _____ DUE TO _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____ <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b> <b>Unknown</b>
---	--

19A. DATE OF OPERATION <b>✓</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>0 8 9 9 8</b>	
22. I hereby certify that I attended the deceased from <b>Aug. 15</b> , 1950, to <b>Oct. 20</b> , 1950 that I last saw the deceased alive on <b>Oct. 20, 1950</b> , and that death occurred at <b>8:35A</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>John L. Wilson, Medical Director</b>		23B. ADDRESS <b>US Marine Hospital, Balto. Md.</b>		23C. DATE SIGNED <b>10/21/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-24-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	
24D. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>		25. FUNERAL DIRECTOR <b>W. W. Chambers Co. Wash. D.C.</b>			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		ADDRESS	

21950 *Washington/Hillman* 246 55

047d

MEDICAL CERTIFICATION

Severely and regidly.

